Original Application

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TN Nursing Services of Morristown

CN1612-042

waller

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December 15, 2016

VIA HAND DELIVERY

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

Dear Melanie:

Please be advised that the applicant requests that the application be placed on the consent calendar. The applicant would expect no opposition to this project since it is not adding any counties to its service area.

If you have any questions or need any additional information, please do not hesitate to call me.

Sincerely,

Kim Harvey Looney

KHL:lag

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. *Name of Facility, Agency, or Institution*

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
Name

409 Cawood Road — Claiborne
Street or Route — County

Tazewell — TN — 37879-3026
City — State — Zip Code

Website address: N/A

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. *Contact Person Available for Responses to Questions*

Kim H. Looney, Esq. — Attorney
Name — Title

Waller Lansden Dortch & Davis LLP — kim.looney@wallerlaw.com
Company Name — Email address

511 Union Street, Suite 2700 — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Attorney — 615-850-8722 — 615-244-6804
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: The applicant is an established home health agency licensed in 11 counties in the northeastern portion of Tennessee. It is seeking to move its principal office from Claiborne County (Tazewell) to Jefferson County (Jefferson City), a distance of just over 49 miles. The applicant also has a branch office in Kingsport (Sullivan County). It will continue to serve the same patient population that it currently serves. The ability to relocate the principal office to an existing branch office and close the existing principal cost will result in reduced administrative costs for the applicant. The applicant anticipates saving $5,000 per month on administrative staffing and $2,250 per month on rent for a total annual savings of $87,000. There is no change in reimbursement as a result of this change.

The applicant sent a letter to the Department of Health, Board for Licensing Health Care Facilities on January 29, 2016 notifying the Board that it was relocating the principal office for its home health agency from Tazewell to Johnson City, TN as well as consolidating its operations in Johnson City, which it had previously operated as a branch office of the agency, effective March 1, 2016. It included its lease and the current state license for their review. At that time, the applicant also stated that it would be notifying CMS to delete the Jefferson City branch designation and to relocate the principal office to this location. On June 21, the applicant received a letter acknowledging the address change of its parent office from Tazewell to Jefferson City, effective March 01, 2016, from the Board for Licensing Health Care Facilities. It also received a new license with the address change.

On February 2, the applicant sent a notice to Palmetto GBA, its fiscal intermediary for Medicare, along with the appropriate CMS855A forms to effect the change described above. A letter dated March 21, 2016 was sent to the applicant from Palmetto GBA on behalf of CMS, which stated it had completed the updates requested effective March 1, 2016. The applicant was totally unaware that such a change required prior approval from the Tennessee Health Services and Development Agency (HSDA). It received a new Tennessee state license with the address change and an approval letter from CMS. It implemented and operated the change in location in reliance upon the approval by both the state and CMS. The applicant did not know it needed to file a CON to relocate the principal office until it received a letter from the Board for Licensing Health Care Facilities, which was not sent until several months after the change had been implemented. The letter was sent from the Director of Licensure and Board for Licensing Health Care Facilities notifying the applicant that it had not received prior approval from the HSDA as required. The applicant, by filing this CON application, is taking steps to comply with this directive.

2) Ownership structure;

Response: The applicant, Tennessee Nursing Services of Morristown, Inc. dba SunCrest Home Health, is owned by SunCrest Home Health of Claiborne County, Inc. An organizational chart is included with this application at Attachment A-4A.

3) Service area;

Response: The applicant is licensed in Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union Counties.

4) Existing similar service providers;

Response: Not applicable. While there are a number of licensed home health agencies in the service area, this is an existing provider that is not seeking to add any counties, so there is no effect on any other providers.

5) Project cost;

Response: The only costs associated with the project are legal fees and the filing fees, which are expected to be approximately $60,000.

6) Funding;

Response: The applicant anticipates funding the minimal project costs from cash reserves.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: Not applicable. This applicant is already licensed and operating and realizing a positive cash margin.

8) Staffing.

Response: The applicant anticipates a reduction in administrative staff as a result of this project. There will be no changes to patient care staffing as a result of this proposal.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: The applicant is seeking approval to relocate its principal office from Tazewell (Claiborne County) to Jefferson City (Jefferson County). The office in Jefferson County has been operating as a branch office. Unlike most CON applications, there are no standards or guidelines for this type of project. The applicant is seeking to consolidate some of its operations in order to reduce the administrative costs of operation. This project accomplishes that objective through a reduction in administrative staff and a closure of one of its offices, for an annual reduction in costs of approximately $87,000 per year. In addition, the relocation will place the principal office in a geographic location that is more centrally located within the service area and is located closer to more of the patients it serves. The applicant will continue to provide the same high quality care to the patients in its service area that it is currently providing to them.

2) Economic Feasibility;

Response: The costs associated with the application are only those that are applicable to the application itself and include legal fees and the HSDA filing fee. The applicant will cut its cost of providing the home health services as it is eliminating the need for a lease in Tazewell and will be able to eliminate a minimum of two administrative staffing positions. The applicant anticipates and annual savings of approximately $87,000.

3) Appropriate Quality Standards; and

Response: The applicant provides high quality services in its 11 county service area as evidenced by the Quality Report from The Joint Commission and the lack of deficiencies in its last licensure survey.

4) Orderly Development to adequate and effective health care.

Response: Not applicable. The requested change does not affect the applicant's current service area or services provided, and it is currently providing effective health care.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: The applicant is requesting that it be put on the consent calendar. Since it is not requesting additional counties, it would not expect opposition for a project that is seeking to relocate its principal office. A letter has been submitted to the Executive Director simultaneously with the filing of this application.

4. SECTION A: PROJECT DETAILS

A. ***Owner of the Facility, Agency or Institution***

SunCrest Home Health of Claiborne County, Inc. (865)465-4138
Name Phone Number

657 Broadway, Suite C Jefferson
Street or Route County

Jefferson City TN 37760-4949
City State Zip Code

B. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship		F.	Government (State of TN or Political Subdivision)	
B.	Partnership		G.	Joint Venture	
C.	Limited Partnership		H.	Limited Liability Company	
D.	Corporation (For Profit)	X	I.	Other (Specify)_____	
E.	Corporation (Not-for-Profit)				

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A.**

Response: See copy of certificate of corporate existence included as Attachment A-4A.

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

5. ***Name of Management/Operating Entity (If Applicable)***

Not applicable
Name

Street or Route County

City State Zip Code

Website address: _____

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5**.

6A. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	_____	D.	Option to Lease	_____
B.	Option to Purchase	_____	E.	Other (Specify) _____	_____
C.	Lease of 3 Years	X		_____	

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

Response: See copy of lease included as Attachment A-6A.

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

   a. Size of site (***in acres***);

   b. Location of structure on the site;

   c. Location of the proposed construction/renovation; and

   d. Names of streets, roads or highway that cross or border the site.

   Response: See plot plan included as Attachment 6B-1.

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

   Response: See floor plan included as Attachment 6B-2.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

Response: Not applicable. This is a home health agency so the patients do not travel to the provider; the provider travels to the patients.

7. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)_____	_____	H	Nursing Home	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____	I.	Outpatient Diagnostic Center	_____
			J.	Rehabilitation Facility	_____
C.	ASTC, Single Specialty	_____	K.	Residential Hospice	_____
D.	Home Health Agency	X	L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	_____
E.	Hospice	_____			
F.	Mental Health Hospital	_____			
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID	_____	M.	Other (Specify)_____	_____

Check appropriate lines(s).

8. **Purpose of Review** ***(Check appropriate lines(s) – more than one response may apply)***

A.	New Institution	_____	F.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	_____
B.	Modifying an ASTC with limitation still required per CON	_____			
C.	Addition of MRI Unit	_____			
D.	Pediatric MRI	_____			
E.	Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify)_____	_____	G.	Satellite Emergency Dept.	_____
			H.	Change of Location	X
			I.	Other (Specify)_____	_____

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

_X_AmeriGroup ___United Healthcare Community Plan _X__BlueCare _X_TennCare Select

Medicare Provider Number **44-7548**

Medicaid Provider Number **00-44-7548**

Certification Type **Home Health Agency**

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __Yes __No _X_N/A Medicaid/TennCare __Yes __No _X_N/A

10. Bed Complement Data **Response:** Not applicable.

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	*Beds Staffed*	*Beds Proposed*	**Beds Approved*	***Beds Exempted*	*TOTAL Beds at Completion*
1) Medical						
2) Surgical						
3) ICU/CCU						
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home -- SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL						

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

11. **Home Health Care Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	X☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	X☐	X☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	X☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	X☐	☐	☐	Sequatchie	☐	☐	☐
Greene	X☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	X☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	X☐	☐	☐	Sullivan	X☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	X☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	X☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	X☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart Response: Not applicable

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF							
*Total Cost							
**Cost Per Square Foot							
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)*					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or

Response: Not applicable.

2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

Response: Not applicable.

A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____ Types: ☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____ Total Cost*: _____ ☐ New ☐ Refurbished	☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___ ☐ If not new, how old? (yrs) _____
☐ MRI	Tesla: ____ Magnet: ☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____ Total Cost*: _____ ☐ New ☐ Refurbished	☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___ ☐ If not new, how old? (yrs) _____
☐ PET	☐ PET only ☐ PET/CT ☐ PET/MRI Total Cost*: _____ ☐ New ☐ Refurbished	☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___ ☐ If not new, how old? (yrs) _____

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Response: Not applicable.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

Response: Not applicable.

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

Response: Not applicable.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

Response: Not applicable.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to
T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

HOME HEALTH SERVICES - STANDARDS AND CRITERIA

1. **Determination of Need:** In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. This 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed Service Area.

   Response: Not applicable. The applicant is not adding any counties to its service area.

2. The need for home health services should be projected three years from the latest available year of final JAR data.

   Response: Not applicable. The applicant is not adding any counties to its service area.

3. The use rate of existing home health agencies in each county of the Service Area will be determined by examining the latest utilization rate as calculated from the JARs of existing home health agencies in the Service Area. Based on the number

of patients served by home health agencies in the Service Area, an estimation will be made as to how many patients could be served in the future.

Response: Not applicable. The applicant is not adding any counties to its service area.

4. **County Need Standard:** The applicant should demonstrate that there is a need for home health services in each county in the proposed Service Area by providing documentation (e.g., letters) where: a) health care providers had difficulty or were unable successfully to refer a patient to a home care organization and/or were dissatisfied with the quality of services provided by existing home care organizations based on Medicare's system Home Health Compare and/or similar data; b) potential patients or providers in the proposed Service Area attempted to find appropriate home health services but were not able to secure such services; c) providers supply an estimate of the potential number of patients that they might refer to the applicant.

   Response: Not applicable. The applicant is not adding any counties to its service area.

5. **Current Service Area Utilization:** The applicant should document by county: a) all existing providers of home health services within the proposed Service Area; and b) the number of patients served during the most recent 12-month period for which data are available. To characterize existing providers located within Tennessee, the applicant should use final data provided by the JARs maintained by the Tennessee Department of Health. In each county of the proposed Service Area, the applicant should identify home health agencies that have reported serving 5 or fewer patients for each of the last three years based on final and available JAR data. If an agency in the proposed Service Area who serves few or no patients is opposing the application, that opponent agency should provide evidence as to why it does not serve a larger number of patients.

   Response: Not applicable. The applicant is not adding any counties to its service area.

6. **Adequate Staffing:** Using TDH Licensure data, the applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and document that such personnel are available to work in the proposed Service Area. The applicant should state the percentage of qualified personnel directly employed or employed through a third party staffing agency.

   Response: Not applicable. The applicant already has the necessary staff to operate the home health agency and it is not adding any counties to its service area.

7. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, referral arrangements with appropriate health care system providers/services (that comply with CMS

patient choice protections) and working agreements with other related community services assuring continuity of care focusing on coordinated, integrated systems. A new provider may submit a proposed community linkage plan.

Response: Not applicable. The applicant is not adding any counties to its service area. The applicant is an existing home health agency with established relationships with area providers.

8. **TennCare Managed Care Organizations (MCOs) and Financial Viability:** Given the time frame required to obtain Medicare certification, an applicant proposing to contract with the Bureau of TennCare's MCOs should provide evidence of financial viability during the time period necessary to receive such certification. Applicants should be aware that MCOs are under no obligation to contract with home care organizations, even if Medicare certification is obtained, and that Private Duty Services are not Medicare certifiable services. Applicants who believe there is a need to serve TennCare patients should contact the TennCare MCOs in the region of the proposed Service Area and inquire whether their panels are open for home health services, as advised in the notice posted on the HSDA website, to determine whether at any given point there is a need for a provider in a particular area of the state; letters from the TennCare MCOs should be provided to document such need. See Note 2 for additional information.

Response: Not applicable. The applicant is already a TennCare provider and is not adding any counties to its service area.

Applicants should also provide information on projected revenue sources, including non-TennCare revenue sources.

Response: Not applicable. The applicant is not adding any counties to its service area. It anticipates that its revenue sources will remain substantially the same. See the table included below in the response to Question 9.

9. **Proposed Charges:** The applicant's proposed charges should be reasonable in comparison with those of other similar agencies in the Service Area or in adjoining service areas. The applicant should list:

    a. The average charge per visit and/or episode of care by service category, if available in the JAR data.

    b. The average charge per patient based upon the projected number of visits and/or episodes of care and/or hours per patient, if available in the JAR data.

Response: Please see information below from the 2015 JAR:

	Gross Revenue	Patients	Visits	Rev/Pat	Rev/Visit
TennCare	$81,590	128	474	$637.42	$172.13
Medicare	$981,679	348	11,805	$2,820.92	$83.16
Medicare HMO	$2,272,690	653	15,126	$3,480.38	$150.25
Commercial	$141,231	162	3,454	$871.80	$40.89
TOTAL	$3,477,190	1,291	30,859	$2,693.41	$112.68

10. **Access:** In concert with the factors set forth in HSDA Rule 0720-11-.01(1) (which lists those factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area for groups with special medical needs such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS patients. Pediatrics is a special medical needs population, and therefore any provider applying to provide these services should demonstrate documentation of adequately trained staff specific to this population's needs with a plan to provide ongoing best practice education. For purposes of this Standard, an applicant should document need using population, service, special needs, and/or disease incidence rates. If granted, the Certificate of Need should be restricted on condition, and thus in its licensure, to serving the special group or groups identified in the application. The restricting language should be as follows: CONDITION: Home health agency services are limited to (identified specialty service group); the expansion of service beyond (identified specialty service group) will require the filing of a new Certificate of Need application. Please see Note 3 regarding federal law prohibitions on discrimination in the provision of health care services.

Response: Not applicable.

11. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting (including data on patient re-admission to hospitals), quality improvement, and an outcome and process monitoring system (including continuum of care and transitions of care from acute care facilities). If applicable, the applicant should provide documentation that it is, or that it intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS.

Response: The applicant currently participates in The Joint Commission's Quality Check Program. A copy of the Quality Report is included as Attachment B, Criteria - Need 11.

12. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services

and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response: The applicant plans to provide the Department of Health and/or the HSDA with all reasonably requested information and data related to the operation of the home health agency.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response: The relocation of the principal office for the applicant is consistent with its long range plans to cut costs where possible in that it allows the applicant to reduce its operating costs for this agency by having two offices instead of 3 in the service area, and reducing the administrative staff, resulting in an average reduction in costs of $87,000.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment – Section – Need-3.**

Response: The applicant is licensed in Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union Counties.

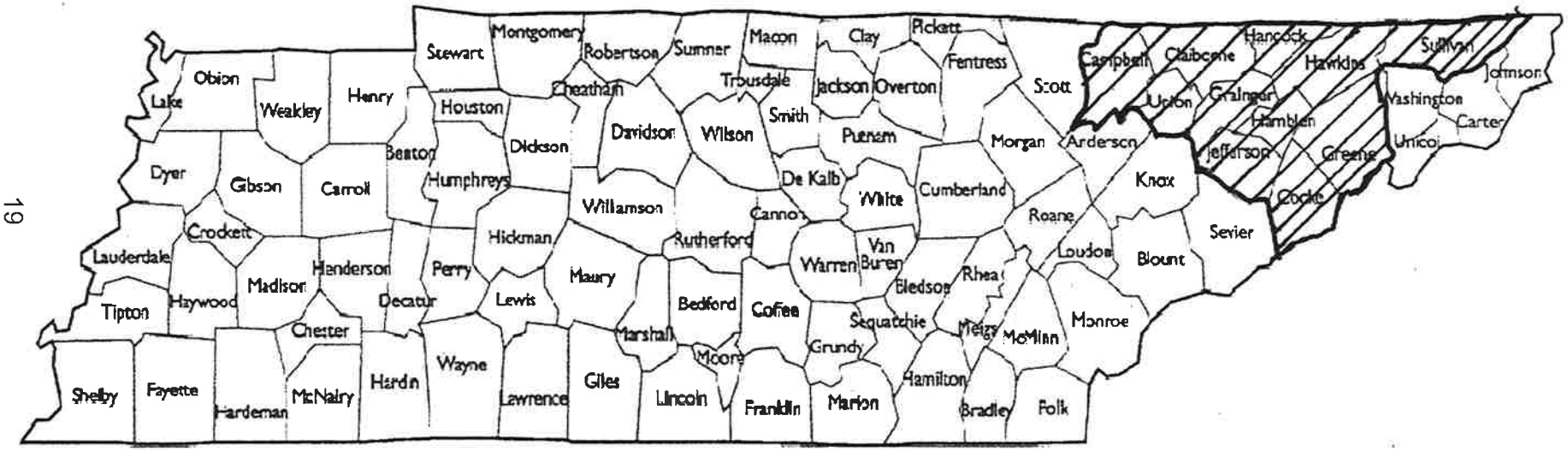
Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents 2015	% of total procedures
Campbell	13	1.96%
Claiborne	184	27.75%
Cocke	28	4.22%
Grainger	55	8.30%
Greene	5	.75%
Hamblen	70	10.56%
Hancock	6	.90%
Hawkins	51	7.69%
Jefferson	48	7.24%
Sullivan	174	26.24%
Union	29	4.37%
Total	663	100.00%

Service Area Counties	Projected Utilization-County Residents	% of total procedures
County #1		
County #2		
Etc.		
Total		100%

Response: Not applicable. Utilization is not expected to change as a result of this project.

County Level Map



SERVICE AREA

4. A. 1) Describe the demographics of the population to be served by the proposal.

2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/ Geographic Area By County	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Campbell	39,758	41,787	5.1%	N/A	N/A	N/A	N/A	43.0	32,028	9,224	23.2%	13,469	33.9%
Claiborne	31,710	34,713	9.5%	N/A	N/A	N/A	N/A	41.8	34,899	6,944	21.9%	9,407	29.7%
Cocke	35,164	37,663	7.1%	N/A	N/A	N/A	N/A	44.3	31,187	9,178	26.1%	11,710	33.3%
Grainger	22,844	24,577	7.6%	N/A	N/A	N/A	N/A	43.6	35,391	4,706	20.6%	6,106	26.7%
Greene	68,585	74,656	8.9%	N/A	N/A	N/A	N/A	43.7	35,196	14,060	20.5%	15,787	24.1%
Hamblen	63,400	67,028	5.7%	N/A	N/A	N/A	N/A	39.9	37,617	13,504	21.3%	16,276	25.7%
Hancock	6,552	7,007	6.9%	N/A	N/A	N/A	N/A	44.2	26,898	1,815	27.7%	2,396	36.8%
Hawkins	56,742	59,784	5.4%	N/A	N/A	N/A	N/A	43.4	36,927	10,838	19.1%	14,066	24.8%
Jefferson	53,250	58,372	9.6%	N/A	N/A	N/A	N/A	42.3	42,417	8,786	16.5%	12,721	23.9%
Sullivan	156,793	159,749	1.9%	N/A	N/A	N/A	N/A	44.3	40,346	27,439	17.5%	33,818	21.6%
Union	19,089	20,320	6.5%	N/A	N/A	N/A	N/A	41.0	37,351	4,104	21.5%	5,234	27.4%
Service Area Total	553,887	585,656	5.7%	N/A	N/A	N/A	N/A	42.9	35,478	110,598	21.5%	140,990	25.5%
State of TN Total	6,600,211	7,108,031	7.7%	N/A	N/A	N/A	N/A	38.4	45,219	1,600,000	17.6%	1,489,597	22.6%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: The applicant currently treats all segments of the population including the elderly, women, racial and ethnic minorities and low income groups.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

   Response: Not applicable. The applicant is requesting relocation of its principal office from Claiborne to Jefferson County. This project has no effect on either the applicant's own utilization or the utilization of other area providers.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

   Response: Not applicable. The applicant is requesting relocation of its principal office from Claiborne to Jefferson County, and the utilization is not relevant to this determination.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   A. All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

   Response: Please see project costs chart. The only costs are the legal fees and the filing fees.

   B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   Response: Not applicable.

   C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

   Response: Not applicable.

   D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

   Response: Not applicable.

   E. For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

      1) A general description of the project;
      2) An estimate of the cost to construct the project;
      3) A description of the status of the site's suitability for the proposed project; and
      4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

   Response: Not applicable.

PROJECT COST CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 45,000
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Total Construction Costs	
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	
	9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify)_____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		
E.	CON Filing Fee		15,000
F.	Total Estimated Project Cost (D+E)	**TOTAL**	$ 60,000

Response: With the exception of legal costs and the filing fee, there are no costs associated with the relocation of the principal office for the applicant. The applicant already operates the office proposed as the principal office as a branch office.

2. Identify the funding sources for this project.

   Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

   __ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

   __ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

   __ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

   __ D. Grants – Notification of intent form for grant application or notice of grant award;

   _X_ E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

   __ F. Other – Identify and document funding from all other sources.

   Response: The applicant anticipates covering the minimal costs associated from cash reserves and has included the appropriate documentation from the Senior Vice President and Secretary of the applicant. The funding letter is included as Attachment C, Economic Feasibility 2-E. The 10K for the parent company, Almost Family, Inc., is included as Attachment C, Economic Feasibility-6.

3. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

   Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

x□ Total Facility
□ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

		Year_____	Year_____	Year_____
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	_____	_____	_____
B.	Revenue from Services to Patients			
	1. Inpatient Services	$_____	$_____	$_____
	2. Outpatient Services	_____	_____	_____
	3. Emergency Services	_____	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____	_____
	Gross Operating Revenue	$_____	$_____	$_____
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$_____	$_____	$_____
	2. Provision for Charity Care	_____	_____	_____
	3. Provisions for Bad Debt	_____	_____	_____
	Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE		$_____	$_____	$_____
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	_____	_____	_____
	b. Non-Patient Care	_____	_____	_____
	2. Physician's Salaries and Wages	_____	_____	_____
	3. Supplies	_____	_____	_____
	4. Rent			
	a. Paid to Affiliates	_____	_____	_____
	b. Paid to Non-Affiliates	_____	_____	_____
	5. Management Fees:			
	a. Paid to Affiliates	_____	_____	_____
	b. Paid to Non-Affiliates	_____	_____	_____
	6. Other Operating Expenses	_____	_____	_____
	Total Operating Expenses	$_____	$_____	$_____
E.	**Earnings Before Interest, Taxes and Depreciation**	$_____	$_____	$_____
F.	Non-Operating Expenses			
	1. Taxes	$_____	$_____	$_____
	2. Depreciation	_____	_____	_____
	3. Interest	_____	_____	_____
	4. Other Non-Operating Expenses	_____	_____	_____
	Total Non-Operating Expenses	$_____	$_____	$_____
NET INCOME (LOSS)		$_____	$_____	$_____

Chart Continues Onto Next Page

NET INCOME (LOSS)	$_____	$_____	$_____
G. Other Deductions			
1. Annual Principal Debt Repayment	$_____	$_____	$_____
2. Annual Capital Expenditure	_____	_____	_____
Total Other Deductions	$_____	$_____	$_____
NET BALANCE	$_____	$_____	$_____
DEPRECIATION	$_____	$_____	$_____
FREE CASH FLOW (Net Balance + Depreciation)	$_____	$_____	$_____

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x□ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	Year_____
1. Professional Services Contract	$_____	$_____	$_____
2. Contract Labor	_____	_____	_____
3. Imaging Interpretation Fees	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
Total Other Expenses	$_____	$_____	$_____

4. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

   The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

x□ Total Facility
□ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

	Year_____	Year_____
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	_____	_____
B. Revenue from Services to Patients		
1. Inpatient Services	$_____	$_____
2. Outpatient Services	_____	_____
3. Emergency Services	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____
Gross Operating Revenue	$_____	$_____
C Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$_____	$_____
2. Provision for Charity Care	_____	_____
3. Provisions for Bad Debt	_____	_____
Total Deductions	$_____	$_____
NET OPERATING REVENUE	$_____	$_____
D. Operating Expenses		
1. Salaries and Wages	_____	_____
a. Direct Patient Care	_____	_____
b. Non-Patient Care	_____	_____
2. Physician's Salaries and Wages	_____	_____
3. Supplies	_____	_____
4. Rent		
a. Paid to Affiliates	_____	_____
b. Paid to Non-Affiliates	_____	_____
5. Management Fees:		
a. Paid to Affiliates	_____	_____
b. Paid to Non-Affiliates	_____	_____
6. Other Operating Expenses	_____	_____
Total Operating Expenses	$_____	$_____
E. **Earnings Before Interest, Taxes and Depreciation**	$_____	$_____
F. Non-Operating Expenses		
1. Taxes	$_____	$_____
2. Depreciation	_____	_____
3. Interest	_____	_____
4. Other Non-Operating Expenses	_____	_____
Total Non-Operating Expenses	$_____	$_____
NET INCOME (LOSS)	$_____	$_____

Chart Continues Onto Next Page

NET INCOME (LOSS)	$_____	$_____
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$_____	$_____
2. Annual Capital Expenditure	_____	_____
Total Other Deductions	$_____	$_____
NET BALANCE	$_____	$_____
DEPRECIATION	$_____	$_____
FREE CASH FLOW (Net Balance + Depreciation)	$_____	$_____

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x□ Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year_____	Year_____
1. Professional Services Contract	$_____	$_____
2. Contract Labor	_____	_____
3. Imaging Interpretation Fees	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
Total Other Expenses	$_____	$_____

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*					
Deduction from Revenue *(Total Deductions/Utilization Data)*					
Average Net Charge *(Net Operating Revenue/Utilization Data)*					

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The applicant does not anticipate any changes to its charges as a result of the implementation of this proposal. The project does not have any incremental revenue and will have no impact on existing patient charges.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Following is information from the 2015 Joint Annual Reports for home health agencies.

HHA	Gross Revenue	Patients	Visits	Rev/Pat	Rev/Visit
Almost Family	$3,477,190	1,291	30,859	$2,693.41	$112.68
Gentiva	$2,040,611	1,912	12,540	$1,067.27	$162.73
Advanced Home Care	$5,562,153	2,287	38,210	$2,432.07	$145.57
Amedisys	$13,632,114	3,099	100,219	$4,398.88	$136.02
Amedisys-Claiborne	$7,701,253	1,551	56,653	$4,965.35	$135.94

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the

project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: Not applicable. The applicant is an operating home health agency with an established track record. There are no costs or charges that are related to this proposal. A copy of the 10K for Almost Family, Inc. is included as Attachment C, Economic Feasibility.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio					

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: The applicant does not anticipate the payor mix changing significantly and has included the information from the JAR for 2015.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$3,254,369	93.59%
TennCare/Medicaid	$ 81,590	2.35%
Commercial/Other Managed Care	$141,231	4.06%
Self-Pay	0	0
Charity Care	0	0
Other (Specify)_____	0	0
Total	$3,477,190	100%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: The table below shows the current staffing according to the 2015 JAR. The applicant anticipates a reduction in administrative staff as a result of this proposal.

Position Classification	Existing FTEs 2015	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
A. Direct Patient Care Positions				
Registered Nurses	4.8	N/A		
Licensed Practical Nurses	3.0	N/A		
Certified Nurse Aides	0	N/A		
Physical Therapy Services	7.6	N/A		
Occupational Therapy	2.6	N/A		
Speech/Language Pathology Services	1.0	N/A		
Medical Social Services	1.0	N/A		
Respiratory Therapists	0	N/A		
Home Health Aide	3.2	N/A		
Homemakers	0	N/A		
Nutritionists/ Dieticians	0	N/A		
Other Health	0	N/A		
Other Non-Health	0	N/A		
Total Direct Patient Care Positions	23.2	N/A		
B. Non-Patient Care Positions				
Administrator	1.0	N/A		
Clinical Director/In-Office Clinical Staff	8.0	7.0		
Office Personnel (Clinical)	4.0	3.0		
Financial/Billing Personnel	0	N/A		
Other Administrative Personnel (Marketing/ Community Education, etc.)	3.0	N/A		
Total Non-Patient Care Positions	16.0	N/A		
Total Employees *(A+B)*	39.2	N/A		
C. Contractual Staff	28.0			
Total Staff *(A+B+C)*	67.2			

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

   A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

   Response: There are no less costly, more effective, and/or more efficient alternatives to this proposal. This request to move the principal office from Claiborne to Jefferson County results in one less office for the agency and a reduction in staff so that expenses are reduced as a result of this proposal.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response: Not applicable. This project does not involve construction.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

   Response: Not applicable. The applicant is an existing home health agency with established relationships.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   A. Positive Effects

   Response: Not applicable. The relocation of a principal office has no effect on competition and does not result in a duplication of services.

   B. Negative Effects

   Response: Not applicable. The relocation of a principal office has no effect on competition and does not result in a duplication of services.

3. A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

   Response: Not applicable. The applicant is an existing licensed home health agency and, as such, meets the required staffing requirements for licensure.

   B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

   Response: The applicant is currently licensed and understands the applicable licensing and certification requirements.

   C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: Not applicable. The applicant does not participate in any student training.

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

   Licensure:

   Response: The applicant is licensed as a home health agency and has received a license from the Tennessee Department of Health, Board for Licensing Health Care Facilities.

   Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

   Response: HHA

   Accreditation (i.e., Joint Commission, CARF, etc.):

   Response: The applicant is accredited by The Joint Commission.

   A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

      Response: The applicant is in good standing with the licensing agency. Attached please find a copy of the current facility license included as Attachment C-4-A.

   B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

      Response: Please see attached copy of the most recent statement of deficiencies/plan of correction. There were no deficiencies.

   C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

      Response: None. The applicant's last survey had no deficiencies.

      1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

         Response: Not applicable.

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

   A. Has any of the following:

      1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response: William B. Yarmuth, CEO, has greater than 5% indirect ownership interest in the applicant through his ownership interest in Almost Family, Inc.

2) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Response: Please see a copy of the organization chart included as Attachment A-4-A. Each subsidiary listed is 100% owned by the corporate entity above. For example, Tennessee Nursing Services of Morristown, Inc. is a wholly owned subsidiary of SunCrest Home Health of Claiborne County, Inc.

3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response: No physician or other entity not already identified has an ownership interest of greater than 5%.

B. Been subjected to any of the following:

1) Final Order or Judgment in a state licensure action;

Response: No.

2) Criminal fines in cases involving a Federal or State health care offense;

Response: No.

3) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: No.

4) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: No.

5) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: No.

6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: No.

7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: No.

8) Is presently subject to a corporate integrity agreement.

Response: No.

6. Outstanding Projects:

A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	Project Name	Date Approved	*Annual Progress Report(s)		Expiration Date
			Due Date	Date Filed	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response: Not applicable.

B. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: Not applicable.

7. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

A. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____

Response: Not applicable.

B. If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?
Response: Not applicable.

C. If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission?

Response: Not applicable.

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The applicant shall report annually such quality information as is requested and appropriate.

STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

   Response: The applicant is a licensed home health agency which is always striving to improve the health and health outcomes of the patients it serves.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

   Response: The residents of the 11 counties in which the applicant is licensed have access to these necessary health care services and thus the ability to strive to achieve optimal health.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response: The applicant is an existing provider of home health services and is seeking to increase economic efficiencies by relocating its principal office and closing the current principal office.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response: The applicant is accredited by The Joint Commission which monitors quality. In addition, it had no deficiencies on its latest survey the Tennessee Department of Health, Board for Licensing Health Care Facilities.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response: The applicant currently has sufficient staff to meet the needs of its patients and seeks to hire only the most highly qualified workers.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Please see proof of publication from the Knoxville News Sentinel (Claiborne, Campbell, Cocke, Grainger, Hamblen, Jefferson and Union Counties); The Greeneville Sun (Greene County); The Rogersville Review (Hawkins and Hancock Counties); and Kingsport Times News (Sullivan County).

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		
2. Architectural and engineering contract signed		
3. Construction documents approved by the Tennessee Department of Health		
4. Construction contract signed		
5. Building permit secured		
6. Site preparation completed		
7. Building construction commenced		
8. Construction 40% complete		
9. Construction 80% complete		
10. Construction 100% complete (approved for occupancy		
11. *Issuance of License		
12. *Issuance of Service		
13. Final Architectural Certification of Payment		
14. Final Project Report Form submitted (Form HR0055)		

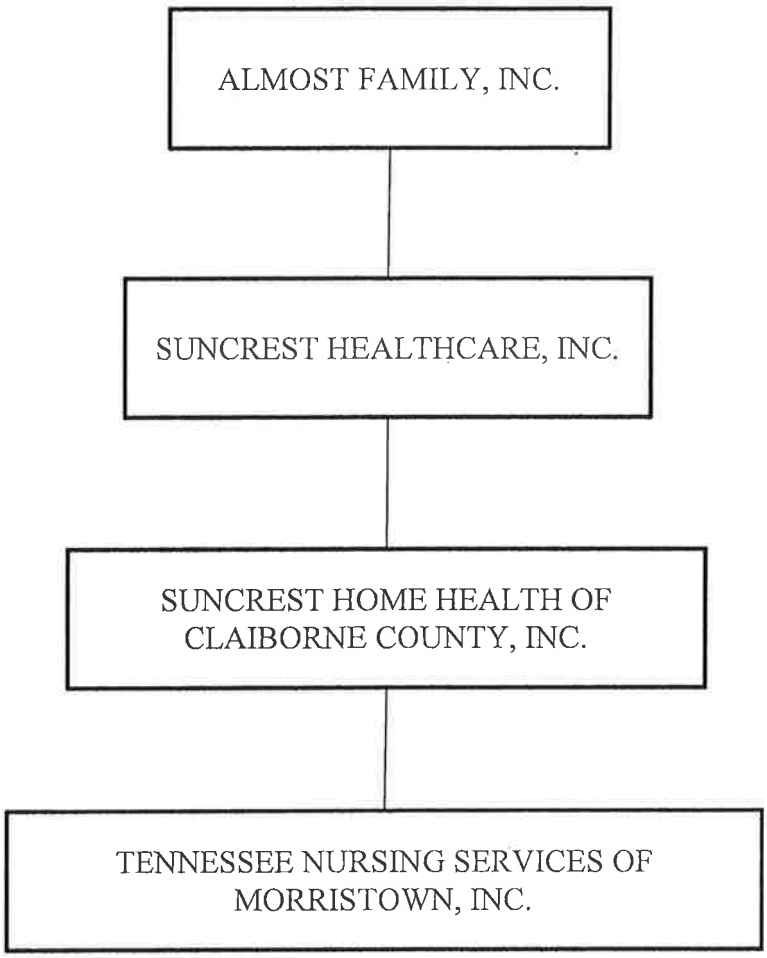
***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

Attachment A-4-A

Organizational Documents
Organizational Chart

ORGANIZATIONAL CHART



Tennessee Secretary of State

Tre Hargett

Business Entity Detail

Available Entity Actions

File Annual Report

Certificate of Existence

Name Business in Tennessee

Entity details cannot be edited. This detail reflects the current state of the filing in the system.

Return to the Business Information Search.

000655066: For-profit Corporation - Domestic

Printer Friendly Version

Name: SunCrest Home Health of Claiborne County, Inc.

Status:	Active	Initial Filing Date:	04/04/2011
Formed in:	TENNESSEE	Delayed Effective Date:	
Fiscal Year Close:	December	AR Due Date:	04/01/2017
Term of Duration:	Perpetual	Inactive Date:	
Principal Office:	9510 ORMSBY STATION RD STE 300 LOUISVILLE, KY 40223-5016 USA		
Mailing Address:	9510 ORMSBY STATION RD STE 300 LOUISVILLE, KY 40223-5016 USA		
AR Exempt:	No	Obligated Member Entity:	No
Shares of Stock:	1,000		

Assumed Names | History | Registered Agent

Name	Status	Expires
No Assumed Names Found...		

Division of Business Services

312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor

Nashville, TN 37243

615-741-2286

8:00 a.m. until 4:30 p.m. (Central) Monday - Friday.

Directions | State Holidays | Methods of Payment

Business Filings and Information (615) 741-2286 | TNSOS.CORPINFO@tn.gov

Certified Copies and Certificate of Existence (615) 741-6488 | TNSOS.CERT@tn.gov

Motor Vehicle Temporary Liens (615) 741-0529 | TNSOS.MVTL@tn.gov

Notary Commissions (615) 741-3699 | TNSOS.ATS@tn.gov

Uniform Commercial Code (UCC) (615) 741-3276 | TNSOS.UCC@tn.gov

Workers' Compensation Exemption Registrations (615) 741-0526 | TNSOS.WCER@tn.gov

Apostilles & Authentications (615) 741-0536 | TNSOS.ATS@tn.gov

Summons (615) 741-1799 | TNSOS.ATS@tn.gov

Trademarks (615) 741-0531 | TNSOS.ATS@tn.gov

Nonresident Fiduciaries (615) 741-0536 | TNSOS.ATS@tn.gov

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Tre Hargett

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **SunCrest Home Health of Claiborne County, Inc.**

General Information

SOS Control #	**000655066**	Formation Locale:	TENNESSEE
Filing Type:	For-profit Corporation - Domestic	Date Formed:	04/04/2011
	04/04/2011 3:45 PM	Fiscal Year Close	12
Status:	Active		
Duration Term:	Perpetual		

Registered Agent Address
NATIONAL CORPORATE RESEARCH, LTD., INC.
STE B
992 DAVIDSON DR
NASHVILLE, TN 37205-1051

Principal Address
STE 300
9510 ORMSBY STATION RD
LOUISVILLE, KY 40223-5016

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
03/28/2016	2015 Annual Report	B0223-6175
03/12/2015	2014 Annual Report	B0065-8536
03/26/2014	2013 Annual Report	A0227-0491
	Principal Address 1 Changed From: 510 HOSPITAL DR To: 9510 ORMSBY STATION RD	
	Principal Address 2 Changed From: STE 100 To: STE 300	
	Principal City Changed From: MADISON To: LOUISVILLE	
	Principal State Changed From: TN To: KY	
	Principal Postal Code Changed From: 37115-5036 To: 40223-5016	
03/19/2013	2012 Annual Report	7168-2108
11/26/2012	Registered Agent Change (by Entity)	7117-0800
	Registered Agent Organization Name Changed From: C T CORPORATION SYSTEM To: NATIONAL CORPORATE RESEARCH, LTD., INC.	
	Registered Agent Physical Address 1 Changed From: 800 S GAY ST To: 992 DAVIDSON DR	
	Registered Agent Physical Address 2 Changed From: STE 2021 To: STE B	
	Registered Agent Physical City Changed From: KNOXVILLE To: NASHVILLE	
	Registered Agent Physical County Changed From: KNOX COUNTY To: DAVIDSON COUNTY	
	Registered Agent Physical Postal Code Changed From: 37929-9710 To: 37205-1051	
03/06/2012	2011 Annual Report	A0106-2409

Filing Information

Name: **SunCrest Home Health of Claiborne County, Inc.**

Principal Address 1 Changed From: 510 HOSPITAL DRIVE SUITE 100 To: 510 HOSPITAL DR

Principal Address 2 Changed From: No value To: STE 100

Principal Postal Code Changed From: 37115 To: 37115-5036

04/04/2011 Initial Filing 6872-0313

Active Assumed Names (if any)	Date	Expires

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **TENNESSEE NURSING SERVICES OF MORRISTOWN, INC.**

General Information

SOS Control #	**000060015**	Formation Locale:	TENNESSEE
Filing Type:	For-profit Corporation - Domestic	Date Formed:	12/04/1978
	12/04/1978 4:30 PM	Fiscal Year Close	12
Status:	Active		
Duration Term:	Perpetual		

Registered Agent Address
NATIONAL CORPORATE RESEARCH, LTD., INC.
STE B
992 DAVIDSON DR
NASHVILLE, TN 37205-1051

Principal Address
STE 300
9510 ORMSBY STATION RD
LOUISVILLE, KY 40223-5016

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
09/07/2016	Assumed Name Renewal	B0296-1508
	Assumed Name Changed From: SunCrest Home Health To: SunCrest Home Health	
	Expiration Date Changed From: 10/13/2016 To: 09/07/2021	
03/28/2016	2015 Annual Report	B0223-6866
03/12/2015	2014 Annual Report	B0065-8690
03/26/2014	2013 Annual Report	A0227-1075
	Principal Address 1 Changed From: 510 HOSPITAL DR To: 9510 ORMSBY STATION RD	
	Principal Address 2 Changed From: STE 100 To: STE 300	
	Principal City Changed From: MADISON To: LOUISVILLE	
	Principal State Changed From: TN To: KY	
	Principal Postal Code Changed From: 37115-5036 To: 40223-5016	
03/29/2013	2012 Annual Report	A0170-0248
	Principal Address 1 Changed From: 409 CAWOOD LANE To: 510 HOSPITAL DR	
	Principal Address 2 Changed From: No value To: STE 100	
	Principal City Changed From: TAZEWELL To: MADISON	
	Principal Postal Code Changed From: 37879 To: 37115-5036	
	Principal County Changed From: CLAIBORNE COUNTY To: DAVIDSON COUNTY	

Filing Information

Name: **TENNESSEE NURSING SERVICES OF MORRISTOWN, INC.**

11/26/2012 Registered Agent Change (by Entity) 7117-0804

Registered Agent Organization Name Changed From: C T CORPORATION SYSTEM To: NATIONAL CORPORATE RESEARCH, LTD., INC.

Registered Agent Physical Address 1 Changed From: 800 S GAY ST To: 992 DAVIDSON DR

Registered Agent Physical Address 2 Changed From: STE 2021 To: STE B

Registered Agent Physical City Changed From: KNOXVILLE To: NASHVILLE

Registered Agent Physical County Changed From: KNOX COUNTY To: DAVIDSON COUNTY

Registered Agent Physical Postal Code Changed From: 37929-9710 To: 37205-1051

12/13/2011 Mailing Address Update

10/13/2011 Assumed Name Change With Name Consent 6948-1996

Consent Method Changed From: No Value To: Both entities will share name and registered agent

New Assumed Name Changed From: No Value To: SunCrest Home Health

Entity Giving Consent Control # Changed From: No Value To: 000534537

Entity Giving Consent Name Changed From: No Value To: SUNCREST HEALTHCARE OF MIDDLE TN, LLC

Duplicate Name Consent DLN Changed From: No Value To: 6948-1998

09/28/2011 Articles of Amendment 6944-0274

Principal Postal Code Changed From: 378790000 To: 37879

Principal County Changed From: Anderson County To: Claiborne County

Fiscal Year Close Changed From: 7 To: 12

09/28/2011 2011 Annual Report A0094-1961

Principal Address 1 Changed From: 1850 OLD KNOXVILLE R To: 409 Cawood Lane

Principal County Changed From: No value To: Anderson County

Registered Agent Organization Name Changed From: No Value To: C T CORPORATION SYSTEM

Registered Agent First Name Changed From: Tim To: No Value

Registered Agent Middle Name Changed From: S To: No Value

Registered Agent Last Name Changed From: Brown To: No Value

Registered Agent Physical Address 1 Changed From: 1850 OLD KNOXVILLE ROAD To: 800 S GAY STREET

Registered Agent Physical Address 2 Changed From: No Value To: SUITE 2021

Registered Agent Physical City Changed From: TAZEWELL To: KNOXVILLE

Registered Agent Physical County Changed From: Claiborne County To: Knox County

Registered Agent Physical Postal Code Changed From: 37879 To: 37929

01/21/2011 2010 Annual Report 6818-1691

01/01/2011 Notice of Determination A0051-1245

09/14/2010 Assumed Name 6769-1687

New Assumed Name Changed From: No Value To: Claiborne Home Health Care, Inc

02/19/2010 2009 Annual Report 6658-0060

Registered Agent First Name Changed From: DANIEL To: Tim

Filing Information

Name: **TENNESSEE NURSING SERVICES OF MORRISTOWN, INC.**

Registered Agent Middle Name Changed From: A To: S
Registered Agent Last Name Changed From: COLON To: Brown
Registered Agent Physical Address 1 Changed From: 1850 OLD KNOXVILLE R To: 1850 OLD KNOXVILLE Road
Registered Agent Physical Address 2 Changed From: PO BOX 219 To: No Value

02/01/2010	Notice of Determination	A0003-0897
09/16/2008	2008 Annual Report	6375-0128
	Registered Agent Changed	
08/03/2007	2007 Annual Report	6106-2028
12/01/2006	2006 Annual Report	5897-0067
07/22/2005	2005 Annual Report	5514-0461
07/23/2004	2004 Annual Report	5192-1191
	Registered Agent Changed	
08/01/2003	2003 Annual Report	4877-0507
10/18/2002	2002 Annual Report	4629-0396
09/24/2001	2001 Annual Report	4305-0248
08/04/2000	2000 Annual Report	3969-1433
07/31/1998	CMS Annual Report Update	3545-0595
	Registered Agent Changed	
07/18/1997	CMS Annual Report Update	3366-0566
	Registered Agent Changed	
02/10/1997	Administrative Amendment	3278-1180
	Fiscal Year Close Changed	
03/06/1995	CMS Annual Report Update	2969-0301
	Mail Address Changed	
04/05/1994	CMS Annual Report Update	2831-2159
	Principal Address Changed	
	Registered Agent Physical Address Changed	
	Registered Agent Changed	
	Mail Address Changed	
03/22/1993	CMS Annual Report Update	2666-2243
	Principal Address Changed	
	Registered Agent Physical Address Changed	
10/07/1992	Articles of Amendment	2564-0292
	Name Changed	
03/18/1992	CMS Annual Report Update	2403-0763
	Principal Address Changed	

Filing Information

Name: **TENNESSEE NURSING SERVICES OF MORRISTOWN, INC.**

02/24/1991 Articles of Amendment	2384-1155
Name Changed	
12/29/1988 Articles of Amendment	1095-0741
Principal Address Changed	
12/04/1978 Initial Filing	044 01471

Active Assumed Names (if any)	Date	Expires
SunCrest Home Health	10/13/2011	09/07/2021

Attachment A-6-A

Lease

OFFICE LEASE AMENDMENT

This office lease amendment is made and entered into this 1st of March 2016 by and between Tennessee nursing services of Morristown, Inc, a Tennessee Corporation d/b/a Suncrest Home Health hospice and private duty (tenant) and Aqueel kouser (landlord)

RECITALS

Whereas landlord and tenant entered into a lease agreement dated as of March 1, 2014 and

Where as landlord has the right to petition the leased premises and Renovate the office space , should landlord have an opportunity to lease unused space .

Where as landlord has been presented with an opportunity to lease space and tenant has agreed to lease additional ~~900 SF~~ 882 TL of space . The landlord will make changes to the space to meet the needs of the Tenant at no extra cost to the tenant

Now therefore the office lease agreement is hereby amended as follows

1 . The premises shall now consist of ~~4200~~ 4,123 TL SF . The floor plan of the new premises is attached as Exhibit B .

2 . Tenant shall pay annual base rent in the amount of ~~50,400~~ 49,476 TL of which Rent will be paid in 12 equal monthly installments of ~~4200~~ 4,123 TL per month (The rent)

3. The effective date of this amendment will be March 1, 2016

4 . All other provisions of the office lease agreement shall remain in full force without change

5 . This amendment will extend the term of the office lease agreement for a total of ~~five years~~ from March 1, 2016 to February 20, ~~2021~~

THREE YEARS FL FEBRUARY 20, 2019 FL

Witness Our hands and ~~seals~~ the Day and year first written above

Landlord

Dr. Aqueel kouser Date 2/16/2016

Tenant

Todd Tyler
SR VICE PRESIDENT

Tennessee nursing services of Morristown Inc.
Suncrest home health hospice and private duty Date 3/17/16

AMENDMENT OF LEASE

This AMENDMENT OF LEASE is made as of the 4th day of March, 2015 by and between Aqueel Kouser (hereinafter referred to as "Lessor") and Tennessee Nursing Services of Morristown, Inc., a Tennessee corporation d/b/a SunCrest Home Health, Hospice and Private Duty (hereinafter referred to as "Lessee").

RECITALS:

WHEREAS, Lessor and Lessee are parties to a certain Lease ("Lease"), dated October 3rd, 2014, and pursuant to which Lessor leased to Lessee and Lessee leased from Lessor the building located at 657 Broadway, Suite B., Jefferson City, Tennessee. and which Lease expires on October 15, 2017; and

WHEREAS, the Parties hereto wish to amend the Lease to correct the legal address of the leased premises:

NOW, THEREFORE, in consideration of the foregoing recitals and for other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree the Premises is hereby revised to be 657 Broadway, Suite C., and Jefferson City, Tennessee.

EXCEPT as expressly provided herein, all other terms and conditions of the Lease Agreement remain unchanged and are hereby ratified and confirmed.

IN WITNESS WHEREOF, the parties hereto have signed and executed Amendment to Lease Agreement on the day and year first written above.

WITNESS: _____ _____
Aqueel Kouser

WITNESS: _____ _____
Tennessee Nursing Services of Morristown, Inc.
Todd Lyles, Sr. Vice President

OFFICE LEASE AMENDMENT

This Office Lease Amendment is made and entered into this ____ day of October, 2014 by and between Tennessee Nursing Services of Morristown, Inc., a Tennessee corporation d/b/a SunCrest Home Health, Hospice and Private Duty ("Tenant"), and Aqueel Kouser ("Landlord").

RECITALS

WHEREAS, Landlord and Tenant entered into a Lease Agreement dated as of March 1, 2014, and

WHEREAS, Landlord has the right to petition the Leased Premises and renovate the office space should Landlord have an opportunity to lease unused space.

WHEREAS, Landlord has been presented with an opportunity to lease additional space, and Tenant has agreed to relocate to ground floor.

NOW THEREFORE, the OFFICE LEASE AGREEMENT is hereby amended as follows:

1. The Premises shall now consist of 3,300 SF, and will be known as Suite B. The floor plan of the new Premises is attached as Exhibit B.

2. Tenant shall pay annual base rent in the amount of $39,000.00 which rent shall be paid in twelve (12) equal monthly installments of $3,300.00 per month ("the Rent").

3. The effective date of this amendment is October 16, 2014, and Rent for October 2014 will be prorated for the effective date, and the monthly Rent will be $2,869.84.

4. All other provisions of the OFFICE LEASE AGREEMENT shall remain in full force without change. 5. This lease is for three years from 10/16/14 to 10/15/17

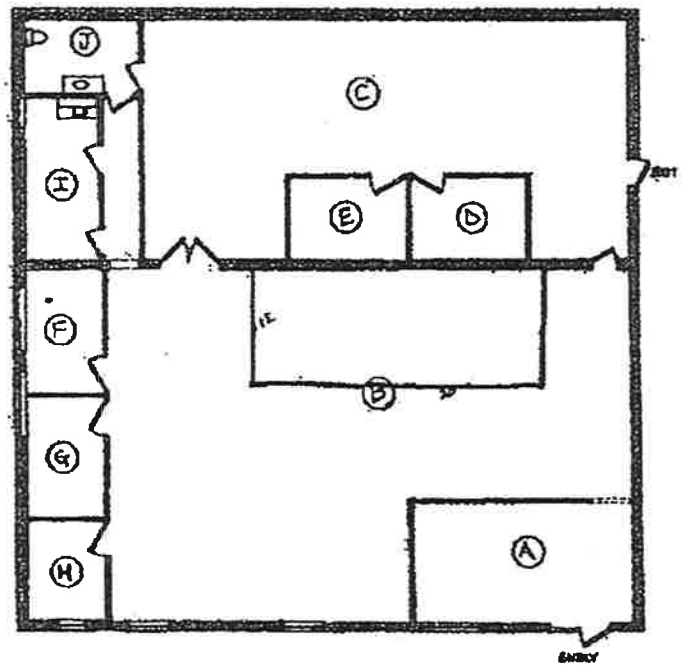
WITNESS our hands and seals the day and year first written above.

LANDLORD

Dr. Aqueel Kouser — Date: 10/3/2014

TENANT
Tennessee Nursing Services of Morristown, Inc.
d/b/a SunCrest Home Health, Hospice and Private Duty

Todd Lyles, Sr. Vice President — Date: 10/3/2014



Building Layout (not to scale)		
	Room	Sq.Ft.
A		250
B		1506
C		902
D		92
E		92
F		90
G		87
N	Storage	76
I	Break Room	126
J	Rest Room	79
	Total Sq.Ft.	3,300

Broadway Plaza Suite B ~~Jefferson~~ City, TN. 37760	
not to scale	9-5-14 Graham 1-423-271-1654
Lower Level Floor Plan	
	1 of 1

Attachment 6-B-1

Plot Plan

Attachment 6-B-2

Floor Plan

Attachment B, Criteria - Need-11

Joint Commission Quality Check Program

The Joint Commission Quality Check®

SunCrest Healthcare of Middle TN LLC

HCO ID: 571218
1210 Briarville Road, Building D
Madison , TN, 37115-5141

Show Keys +

2013 Safety Goals

Improve the accuracy of patient identification.

Organizations Should

Use of Two Patient Identifiers

Implemented

Improve the safety of using medications.

Organizations Should

Reconciling Medication Information

Implemented

Reduce the risk of health care-associated infections.

Organizations Should

Meeting Hand Hygiene Guidelines

Implemented

Reduce the risk of patient harm resulting from falls.

Organizations Should

Implementing a Fall Reduction Program

Implemented

The organization identifies safety risks inherent in its patient population.

Organizations Should

Identifying Risks Associated with Home Oxygen

Implemented

SunCrest Healthcare of Middle TN LLC

Organization ID: 571218

1210 Briarville Road, Building DMadison, TN 37115-5141

Accreditation Activity - Measure of Success Form

Due Date: 8/31/2016

OME Standard LD.04.01.07 The organization has policies and procedures that guide and support patient care, treatment, or services.

Elements of Performance:

2. The organization manages the implementation of policies and procedures.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 90
Month 2 Date: 06/16
Month 2 Actual Goal (%): 91
Month 3 Date: 07/16
Month 3 Actual Goal (%): 92
Month 4 Date: 08/16
Month 4 Actual Goal (%): 90
Actual Average Goal (%): 90
Optional Comments:

OME Standard NPSG.03.06.01 Maintain and communicate accurate patient medication information.

Elements of Performance:

1. Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications.

Note 1: The organization obtains the patient's medication information during the first contact. The information is updated when the patient's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 88
Month 2 Date: 06/16
Month 2 Actual Goal (%): 90
Month 3 Date: 07/16
Month 3 Actual Goal (%): 89
Month 4 Date: 08/16
Month 4 Actual Goal (%): 94
Actual Average Goal (%): 90
Optional Comments:

3. Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 89
Month 2 Date: 06/15
Month 2 Actual Goal (%): 92
Month 3 Date: 07/16
Month 3 Actual Goal (%): 95
Month 4 Date: 08/16
Month 4 Actual Goal (%): 98
Actual Average Goal (%): 93
Optional Comments:

OME Standard NPSG.15.02.01 Identify risks associated with home oxygen therapy such as home fires.

Elements of Performance:

1. Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: - Whether there are smoking materials in the home - Whether or not the home has functioning smoke detectors Note:

Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required. - Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 88
Month 2 Date: 06/16
Month 2 Actual Goal (%): 90
Month 3 Date: 07/16
Month 3 Actual Goal (%): 92
Month 4 Date: 08/16
Month 4 Actual Goal (%): 98
Actual Average Goal (%): 92
Optional Comments:

3. Inform and educate the patient, family, and/or caregiver about the following: - The findings of the safety risk assessment - The causes of fire - Fire risks for neighboring residences and buildings - Precautions that can prevent fire-related injuries - Recommendations to address the specific identified risk(s) Document the provision of information and education. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 90
Month 2 Date: 06/16
Month 2 Actual Goal (%): 95
Month 3 Date: 07/16
Month 3 Actual Goal (%): 93
Month 4 Date: 08/16
Month 4 Actual Goal (%): 92
Actual Average Goal (%): 92
Optional Comments:

4. Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 89
Month 2 Date: 06/16
Month 2 Actual Goal (%): 90
Month 3 Date: 07/16
Month 3 Actual Goal (%): 92
Month 4 Date: 08/16

Month 4 Actual Goal (%): 92
Actual Average Goal (%): 91
Optional Comments:

OME Standard PC.01.02.01 The organization assesses and reassesses its patients.

Elements of Performance:

23. During patient assessments and reassessments, the organization gathers the data and information it requires.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 91
Month 2 Date: 06/16
Month 2 Actual Goal (%): 90
Month 3 Date: 07/16
Month 3 Actual Goal (%): 94
Month 4 Date: 08/16
Month 4 Actual Goal (%): 97
Actual Average Goal (%): 93
Optional Comments:

OME Standard PC.01.03.01 The organization plans the patient's care.

Elements of Performance:

1. The organization plans the patient's care, treatment, or services based on needs identified by the patient's assessment. Note 1: The patient's strengths are considered along with his or her identified needs. Note 2: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 95
Month 2 Date: 06/16
Month 2 Actual Goal (%): 95
Month 3 Date: 07/16

Month 3 Actual Goal (%): 95
Month 4 Date: 08/16
Month 4 Actual Goal (%): 98
Actual Average Goal (%): 96
Optional Comments:

OME Standard PC.02.01.05 **The organization provides interdisciplinary, collaborative care, treatment, or services.**

Elements of Performance:

1. All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 90
Month 2 Date: 06/16
Month 2 Actual Goal (%): 90
Month 3 Date: 07/16
Month 3 Actual Goal (%): 92
Month 4 Date: 08/16
Month 4 Actual Goal (%): 90
Actual Average Goal (%): 90
Optional Comments:

8. The organization informs the physician when there is an unanticipated change in the patient's condition or the patient is discharged or transferred.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 92
Month 2 Date: 16/16
Month 2 Actual Goal (%): 95
Month 3 Date: 07/16
Month 3 Actual Goal (%): 94
Month 4 Date: 08/16
Month 4 Actual Goal (%): 96
Actual Average Goal (%): 94
Optional Comments:

OME Standard RC.02.01.01

The patient record contains information that reflects the patient's care, treatment, or services.

Elements of Performance:

2. The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s) - The patient's medical history - Any allergies or sensitivities - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, frequency, and route of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician. (See also PC.01.02.01, EP 1; PC.01.03.01, EPs 1 and 23) Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.

Scoring Category: C
Stated Goal (%): 100
Month 1 Date: 05/16
Month 1 Actual Goal (%): 92
Month 2 Date: 06/16
Month 2 Actual Goal (%): 89
Month 3 Date: 07/16
Month 3 Actual Goal (%): 90
Month 4 Date: 08/16
Month 4 Actual Goal (%): 94
Actual Average Goal (%): 91
Optional Comments:

Attachment C, Economic Feasibility - 2-E

Funding Documentation

Almost Family, Inc.
9510 Ormsby Station Road, Suite 300
Louisville, KY 40223
502.891.1000 Fax: 502.891.8067

December 14, 2016

Tennessee Department of Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502m Deaderick Street
Nashville, TN 37243

RE: Certificate of Need
Applicant: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
Lic. #: 0000000093

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health has filed a Certificate of Need Application to move its principal office. The Board of Directors of Tennessee Nursing Services of Morristown have approved the filing of the CON Application, and agreed to provide funding for this application.

Tennessee Nursing Services of Morristown is a fourth tier, wholly owned subsidiary of the public company, Almost Family, Inc. As the ultimate parent company, Almost Family, Inc. also agrees to guarantee all financial obligation of the subsidiary for this CON project

If you have any questions, please feel free to contact me at (502) 891-1044.

Sincerely,

Patrick Todd Lyles
Sr. Vice President & Secretary
Tennessee Nursing Services of Morristown, Inc.

The financial obligations for the Certificate of Need application of Tennessee Nursing Services of Morristown will be guaranteed by the corporate parent.

Almost Family, Inc.

William B. Yarmuth
Chairman & CEO

Attachment C, Economic Feasibility - 6

Almost Family, Inc. Form 10K

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended January 1, 2016

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to

Commission file number **001-09848**

ALMOST FAMILY, INC.

(Exact name of Registrant as specified in its charter)

Delaware	**06-1153720**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

9510 Ormsby Station Road, Suite 300, Louisville, Kentucky 40223
(Address of principal executive offices)

(502) 891-1000
(Registrant's telephone number, including area code)

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act

Title of each class	Name of each exchange on which registered
Common Stock, par value $0.10 per share	NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☒
Non-accelerated filer ☐	Smaller reporting company ☐
(Do not check if a smaller reporting company)	

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant as of the last day of the second fiscal quarter ended July 3, 2015 was $334,169,264 based on the last sale price of a share of the common stock as of July 2, 2015 ($39.21), as reported by the NASDAQ Global Market.

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

Class	Outstanding at March 2, 2016
Common Stock, $0.10 par value per share	10, 299,575 Shares

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the 201 6 definitive proxy statement relating to the registrant's Annual Meeting of Stockholders are incorporated by reference in Part III to the extent described therein.

TABLE OF CONTENTS

In this report, the terms "Company," "we," "us" or "our" mean Almost Family, Inc. and all subsidiaries included in our consolidated financial statements.

Special Caution Regarding Forward-Looking Statements

Certain statements contained in this annual report on Form 10-K, including, without limitation, statements containing the words "believes," "anticipates," "intends," "expects," "assumes," "trends" and similar expressions, constitute "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are based upon the Company's current plans, expectations and projections about future events. However, such statements involve known and unknown risks, uncertainties and other factors that may cause the actual results, performance or achievements of the Company to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. These factors include, among others, the following:

- general economic and business conditions;
- demographic changes;
- changes in, or failure to comply with, existing governmental regulations;
- legislative proposals for healthcare reform;
- changes in Medicare and Medicaid reimbursement levels;
- changes in laws and regulations with respect to Accountable Care Organizations;
- effects of competition in the markets in which the Company operates;
- liability and other claims asserted against the Company;
- potential audits and investigations by government and regulatory agencies, including the impact of any negative publicity or litigation;
- ability to attract and retain qualified personnel;
- availability and terms of capital;
- loss of significant contracts or reduction in revenues associated with major payor sources;
- ability of customers to pay for services;
- business disruption due to natural disasters or terrorist acts;
- ability to successfully integrate the operations of acquired businesses and achieve expected synergies and operating efficiencies from the acquisition, in each case within expected time-frames or at all;
- ability to successfully develop investments made by our healthcare innovations segment, in light of the highly speculative nature of these early stage investments;
- significant deterioration in economic conditions and significant market volatility;
- effect on liquidity of the Company's financing arrangements; and
- changes in estimates and judgments associated with critical accounting policies and estimates.

For a detailed discussion of these and other factors that could cause the Company's actual results to differ materially from the results contemplated by the forward-looking statements, please refer to Item 1A. "Risk Factors" and Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" elsewhere in this report. The reader should not place undue reliance on forward-looking statements, which speak only as of the date of this report. Except as required by law, the Company does not intend to publicly release any revisions to forward-looking statements to reflect unforeseen or other events after the date of this report. The Company has provided a detailed discussion of risk factors within this annual report on Form 10-K and various filings with the Securities and Exchange Commission ("SEC"). The reader is encouraged to review these risk factors and filings.

PART I

ITEM 1. BUSINES S

Introduction

Almost Family, Inc. ™ and subsidiaries (collectively " *Almost Family* ") is a leading, regionally focused provider of home health services. We have service locations in Florida, Ohio, Tennessee, New York, Kentucky, Connecticut, New Jersey, Massachusetts, Indiana, Illinois, Pennsylvania, Georgia, Missouri, Mississippi and Alabama (in order of revenue significance in 2015).

We were incorporated in Delaware in 1985. Through a predecessor merged into the Company in 1991, we have been providing health care services, primarily home health care, since 1976. We reported approximately $532 million of revenues for the year ended January 1, 2016 . Unless otherwise indicated, the financial information included in Part I is for continuing operations.

Website Access to Our Reports

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to those reports are available free of charge on our website at www.almostfamily.com as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC. Information contained on Almost Family's website is not part of this annual report on Form 10-K and is not incorporated by reference in this document.

How We Are Currently Organized and Operate

The Company has two divisions, Home Health care and Healthcare Innovations. The Home Health care division is comprised of two reportable segments, Visiting Nurse Services (VN or Visiting Nurse) and Personal Care Services (PC or Personal Care). Healthcare Innovations is also a reporting segment. Reportable segments have been identified based upon how management has organized the business by services provided to customers and the criteria in Accounting Standards Codification (ASC) Topic 280, *Segment Reporting* .

Our VN segment provides a comprehensive range of Medicare-certified home health nursing services to patients in need of recuperative care, typically following a period of hospitalization or care in another type of inpatient facility. Our services are often provided to patients in lieu of additional care in other settings, such as long term acute care hospitals, inpatient rehabilitation hospitals or skilled nursing facilities. Our nurses, therapists, medical social workers and home health aides work closely with patients and their families to design and implement an individualized treatment response to a physician-prescribed plan of care. Under the umbrella of our "Senior Advocacy" mission, we offer special clinically-based protocols customized to meet the needs of the increasingly medically complex, chronic and co-morbid patient populations we serve. Examples include Optimum Balance, Silver Steps, Cardiocare, Orthopedic and Conjestive Heart Failure in the Home. VN Medicare revenues are generated on a per episode basis rather than a fee per visit or hourly basis. Approximately 94% of the VN segment revenues are generated from the Medicare program while the balance is generated from Medicaid and private insurance programs.

Our PC segment provides services in patients' homes primarily on an as-needed, hourly basis. These services include personal care, medication management, meal preparation, caregiver respite and homemaking. Our services are often provided to patients who would otherwise be admitted to skilled nursing facilities for long term custodial care. PC revenues are generated on an hourly basis. Approximately 83% of the PC segment revenues are generated from Medicaid and other government programs while the balance is generated from insurance programs and private pay patients.

The Healthcare Innovations segment includes our developmental activity outside of the traditional home health business platform.

Additional financial information about our segments can be found in Part II, Item 8, "Notes to Consolidated Financial Statements" and related notes included elsewhere in this Form 10-K.

Our View on Reimbursement and Diversification of Risk

Our Company is highly dependent on government reimbursement programs which pay for the majority of the services we provide to our patients and customers. Reimbursement under these programs, primarily Medicare and Medicaid, is subject to frequent changes as policy makers balance constituents' needs for health care services within the constraints of the specific government's fiscal budgets. Medicare and Medicaid, respectively, are consuming a greater percentage of federal and states' budgets, which is exacerbated in times of economic downturn. We believe that these financial issues are cyclical in nature rather than indicative of the long-term prospect for Medicare and Medicaid funding of health care services. Additionally, we believe our services offer the lowest cost alternative to institutional care and are a part of the solution to the federal government's Medicare and states' Medicaid financing problems.

We believe that an important key to our historical success and to our future success is our ability to adapt our operations to meet changes in reimbursement as they occur. One important way in which we have achieved this adaptability in the past, and in which we plan to achieve it in the future, is to maintain some level of diversification in our business mix.

The execution of our business plan will place primary emphasis on the development of our home health operations. As our business grows, we may evaluate opportunities for the provision of other health care services in patients' homes that would be consistent with our Senior Advocacy mission.

Our Business Plan

Our future success depends on our ability to execute our business plan. Over the next three to five years we will try to accomplish the following:

- Generate meaningful same store sales growth through the focused provision of high quality services and attending to the needs of our patients;
- Drive our costs down, while continuing to provide high quality patient care, by improving the productivity of our work force through improved monitoring, tighter controls, workflow automation, use of technology and other opportunities for efficiency gains;
- Expand the significance of our home health services by selectively acquiring other quality providers, through the startup of new agencies and potentially by providing new services in patients' homes consistent with our Senior Advocacy mission;
- Make additional strategic investments which expand our Healthcare Innovation segment in its mission to find solutions for more effective, efficient and appropriate delivery of homecare; and
- Expand our capital base through both earnings performance and by seeking additional capital investments in our Company.

Overview of Our Services

Home Health Division Services

Operating Locations

Our operating locations for our VN and PC Segments in our home health division as of fiscal year end were as follows:

	2015 Branches		2014 Branches	
Geographic Clusters	Visiting Nurse	Personal Care	Visiting Nurse	Personal Care
Southeast				
Florida	48	7	51	7
Tennessee	23	8	23	8
Georgia	9	—	9	—
Mississippi	2	—	2	—
Alabama	1	—	1	—
Northeast				
Pennsylvania	6	2	8	2
New Jersey	6	—	6	—
New York	5	7	—	—
Massachusetts	5	—	5	—
Connecticut	4	8	3	7
Midwest				
Kentucky	21	4	21	4
Ohio	16	38	12	33
Indiana	9	—	11	—
Missouri	4	—	4	—
Illinois	3	—	4	—
Total	162	74	160	61

Late in the fourth quarter of 2015, we closed or merged certain underperforming locations in Florida, Pennsylvania, Indiana, and Illinois. On August 29 and on November 5 , 2015, we acquired operating locations in New York and Connecticut, and Ohio, respectively.

Visiting Nurse Services

Our VN segment services consist primarily of the provision of skilled in-home medical services to patients in need of short-term recuperative health care. Our patients are referred to us by their physicians or upon discharge from a hospital or other type of in-patient facility. We operate 94 Medicare-certified home health agencies with a total of 16 2 locations. In the fiscal year ended January 1, 2016 , approximately 94% of our visiting nurse segment revenues were derived from the Medicare program.

Our Visiting Nurse segment provides a comprehensive range of Medicare-certified home health nursing services. We receive payment from Medicare, Medicaid and private insurance companies. Our professional staff includes registered nurses, licensed practical nurses, physical, speech and occupational therapists, and medical social workers. They fulfill medical treatment plans prescribed by physicians. Our professional staff is subject to state licensing requirements in the particular states in which they practice. Para-professional staff members (primarily home health aides) also provide care to these patients.

Our Visiting Nurse segment operations located in Florida normally experience higher admissions during the first quarter and lower admissions during the third quarter than in the other quarters due to seasonal population fluctuations.

Personal Care Services

Our PC segment services are also provided in patients' homes. These services (generally provided by para-professional staff such as home health aides) are generally of a custodial rather than skilled nature. Generally, PC revenues are generated on an hourly basis. We currently operate 74 Personal Care locations. In the fiscal year ended January 1, 2016 , approximately 83% of our personal care segment revenues were derived from the Medicaid program.

Healthcare Innovations Segment

Our HealthCare Innovations (HCI) business segment was created to house and separately report on our developmental activities outside our traditional home health business platform. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and payers through the enhanced provision of home health services. HCI activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. These include, but are not limited to: technology, information, population health management, risk-sharing, assessments, care coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision making. We believe these activities help us discover valuable insight and experiences that would not otherwise be gained in the routine operation of our core home health business segments. Further, we believe these innovation activities, will play an important role in collaborating with policy makers, payers, providers, and anyone who assumes financial risk for managing patient populations, to seek to reduce costs , and improve quality by providing increasingly more care for more patients in their homes than ever before.

As discussed further below, the HCI segment now includes: a) Imperium Health Management, an ACO enablement company, b) an investment in NavHealth, a population-health analytics company, c) Ingenios Health, a Nurse-Practitioner-oriented and mobile technology-enabled health risk assessment company primarily serving managed care organizations; and d) Long Term Solutions, an in-home assessment company serving the long-term care insurance industry.

Some of these initiatives are highly speculative and have been made in development stage enterprises. There can be no assurance that we will receive any return on, or of, the capital we invest in these ventures. However, we believe these activities already have, and will continue to help us, discover valuable insigh ts and experiences we would not otherwise gain in the routine operation of our core home health business segments. These endeavors are part of a growing number of care-related innovations and reforms. We expect more will be attempted over the next several years.

Imperium

Imperium's purpose is to assist independent primary care physician practices in establishing and successfully operating Accountable Care Organizations ("ACOs") first made possible by 2010's Affordable Care Act. Through improved care management, in a coordinated effort led by primary care physicians, with nurses and home health agencies using evidence-based clinical standards, we seek to reduce avoidable hospitalizations, emergent care, and non-impactful health care services. We seek to work together with primary care physicians to manage high-cost patients in lower-cost settings, with a goal of generating, and sharing in, savings to the Medicare program. By linking physicians with home health care through the ACO vehicle we seek to deliver meaningful savings to the healthcare system and participate in a share of those savings under the Medicare Shared Savings Program ("MSSP") and such other similar models as may evolve in the future.

In the past year, Imperium has rapidly expanded its customer base growing from 3 ACOs under contract in 2013, to 7 in 2014 , 11 in 2015 and 14 in 2016 . In terms of covered Medicare beneficiaries, Imperium has grown from 23,000 in 2013, to 45,000 in 2014 and 85,000 in 2015 and now has 124,000 in 2016 . While we intend to work together toward the development of additional ACO relationships in markets in which Almost Family also provides home health services, Imperium also currently has, and will continue to seek, ACO customers in other service territories. We own 61.5% of Imperium and consolidate its result in our financial statements. We report a provision for noncontrolling

interests (NCI) to reflect the income or losses attributable to the 38.5% interest that we do not own. Additionally, due to certain put-call arrangements we also reflect a mandatorily redeemable noncontrolling interest amount of $3.6 million related to Imperium between the liability and equity sections of our balance sheet.

CMS announced the first year financial reconciliation and quality performance results for ACOs in September of 2014, in which, fifty-three ACOs generated shared savings during their first performance year ended December 31, 2013. ACOs that generated savings earned a performance payment, if they met the quality standard. CMS announced the second year results in September of 2015. An Imperium serviced ACO received an MSSP payment in the first and second CMS results. Imperium received its share $1.4 million in 2015 for 2014 services and $1.6 million in 2014 for 2013 services. There can be no assurance that future payments will be made by CMS, the structure of MSSP payments will remain as currently deployed, or that an MSSP payment will be received in 2016 related to our 2015 services or any future period.

NavHealth

NavHealth is a development-stage enterprise whose business plan is focused on the development of technology-based tools designed to help health systems anticipate and inform a patient's journey through the health care system. Among its other objectives, NavHealth seeks to develop and market a software platform designed to assist health care providers, managed care organizations and insurers in their efforts to aggregate patient data from various sources, improve patient engagement, satisfaction and outcomes and lower the overall cost of healthcare delivery. We are co-invested in NavHealth with founders Aneesh Chopra and Hunch Analytics which Chopra co-founded with Sanju Bansal. Mr. Bansal is the co-founder and former COO of MicroStrategy (MSTR), a worldwide provider of enterprise software for cloud business intelligence and big data services. We made an initial $1 million noncontrolling investment in NavHealth on January 29, 2015 and may, at our option, invest another $1 million. We account for this non-controlling investment under the cost method.

Ingenios Health Co.

Ingenios Health Co. ("Ingenios") is a provider of technology enabled in-home clinical assessments for Medicare Advantage, Managed Medicaid and Commercial Exchange lives in seven states and Washington, D.C. We believe new health assessment capabilities provide the key element in the evolution of improved care planning and delivery as healthcare delivery and reimbursement models evolve.

Long-Term Solutions

On January 5, 2016, we acquired Long Term Solutions , Inc. (" LTS "). See "Acquisitions" for additional information. LTS performs in-home nursing assessments for the long-term care insurance industry. LTS also provides a suite of planning and support services to insurance companies, employers and direct to individuals and families throughout the United States. LTS, through its network of thousands of assessment service partners provides assessments in all 50 U.S. states and a number of foreign countries. LTS estimates that the majority of its assessments result in the patient ultimately receiving home health, assisted living or skilled nursing care in accordance with their long-term care insurance benefits. One of every four of LTS's 2015 assessments was performed in territories currently served by our home health operations.

The American Association for Long-Term Care Insurance (" AALTCI ") estimates that the industry paid over $7.5 billion in claims covering 273,000 beneficiaries across the US in its most recently studied year and that over two thirds of all newly-opened long term care insurance claims paid for care in the home or in an assisted living community setting. The AALTCI also reported total benefit payments increased by 13 percent and the number of long term care insurance policyholders on claim grew 3.4 percent. According to the National Association of Insurance Commissioners (" NAIC ") the top 100 plans in the US cover 7.2 million lives.

Compensation for Home Health Services

We are compensated for our home health services by (i) Medicare (Visiting Nurse segment only), (ii) Medicaid, (iii) other third party payors (e.g., insurance companies and other sources), and (iv) private pay (paid by personal funds). The rates of reimbursement we receive from Medicare, Medicaid and other government programs are generally dictated by those programs. In determining charge rates for goods and services provided to our other customers, we evaluate several factors including cost and market competition. We sometimes negotiate contract rates with third party providers such as insurance companies.

Our reliance on government sponsored reimbursement programs makes us vulnerable to possible legislative and administrative regulation changes and budget cut-backs that could adversely affect the number of persons eligible for such programs, the amount of allowed reimbursements or other aspects of the programs, any of which could materially affect us. In addition, loss of certification or qualification under Medicare or Medicaid programs could materially affect our ability to effectively market our services.

The following table sets forth our revenues from operations derived from each major payor class during the indicated periods (by percentage of net revenues) for the fiscal years ended:

Payor Group	January 1, 2016	December 31, 2014	December 31, 2013
Medicare	71.4 %	72.4 %	71.2 %
Medicaid and Other Government Programs	22.5 %	19.6 %	22.5 %
Insurance and private pay	6.1 %	8.0 %	6.3 %

Medicare revenues are earned in our VN segment, where they account for 94% of segment revenues. Historical changes in payment sources are primarily a result of changes in the types of customers we attract.

See "Government Regulation" and "Risk Factors." We will monitor the effects of such items and may consider modifications to our expansion and development strategy when and if necessary.

Acquisitions

The Company has completed several acquisitions over the past three years and will continue to seek to acquire other quality providers of Medicare-certified home health and/or personal care services, along with making investments in healthcare innovators through our Healthcare Innovations segment.

Factors which may affect future acquisition decisions include, but are not limited to, the quality and potential profitability of the business under consideration, and our profitability and ability to finance the transaction.

2016 Acquisitions

On January 5, 2016, we acquired 100% of the equity of Long Term Solutions, Inc. ("LTS"). LTS is a provider of in-home nursing assessments for the long-term care insurance industry. LTS provides assessments in all 50 U.S. states and a number of foreign countries. The purchase price of $37 million was funded through borrowings on the Company's bank credit facility, seller notes and issuance of the Company's common stock. LTS's post acquisition operating results will be reported in our Healthcare Innovations business segment.

On January 5, 2016, we purchased the assets of a Medicare-certified home health agency owned by Bayonne Visiting Nurse Association ('Bayonne") located in New Jersey. Bayonne's post acquisition operating results will be reported in our VN segment.

2015 Acquisitions

On November 5, 2015, we acquired the stock of Black Stone Operations, LLC ("Black Stone"). Black Stone is a provider of in-home personal care and skilled home health services in western Ohio and operates under the name "Home Care by Black Stone ." The purchase price of $40 million was funded through borrowings on the Company's bank credit

facility, seller notes and issuance of the Company's common stock. Black Stone's post acquisition operating results are reported in our VN and PC segments.

On July 22, 2015, we acquired 100% of the equity of Ingenios Health Co. ("Ingenios") for approximately $11.4 million of the Company's common stock plus $2 million in cash. Ingenios is a leading provider of technology enabled in-home clinical assessments for Medicare Advantage, Managed Medicaid and Commercial Exchange lives in seven states and Washington, D.C. The post acquisition operating results of Ingenios are reported in our Healthcare Innovations business segment.

On August 29, 2015, we acquired 100% of the equity of Bracor, Inc. (dba "WillCare"). Willcare, based in Buffalo, NY, owned and operated VN and PC branch locations in New York (1 2) and Connecticut (1). The purchase price was approximately $50.8 million. The transaction was funded by borrowings under the Company's bank credit facility. WillCare's New York and Connecticut post acquisition operating results are reported in our VN and PC segments.

On March 1, 2015, we acquired the stock of WillCare's Ohio operations for $3.0 million. WillCare's Ohio post acquisition operating results are reported in our VN and PC segments.

On January 29, 2015, we acquired a noncontrolling interest in a development stage analytics and software company, NavHealth, Inc. ("NavHealth"). The investment is an asset of our Health care Innovations segment.

2014 Acquisitions

During 2014, we completed a small acquisition using cash on hand to expand existing VN segment operations in Kentucky.

2013 Acquisitions

On December 6, 2013, we acquired the stock of Omni Home Health Holdings, Inc. ("SunCrest"). The total purchase price was $ 76.6 million . The transaction was funded primarily from borrowings from our senior secured revolving credit facility and cash on hand. SunCrest's post acquisition operating results are included in our VN segment and our PC segment.

On October 4, 2013, we acquired a controlling interest in Imperium Health Management, LLC ("Imperium"). Imperium is a development-stage enterprise that provides strategic health management services to Accountable Care Organizations ("ACOs"). We acquired 61.5% interest for a total of $5.8 million. The transaction was funded with cash on hand. Imperium's post acquisition operating results are included in our Healthcare Innovations segment.

On July 17, 2013, we acquired the assets of the Medicare-certified home agencies owned by Indiana Home Care Network ("IHCN"). IHCN operated six home health agencies primarily in northern Indiana. The total purchase price was $12.5 million and was funded with cash on hand and Almost Family, Inc. common stock. ICHN's post acquisition operating results are reported in our VN segment.

Competition, Marketing and Customers

The visiting nurse industry is highly competitive and fragmented. Competitors include larger publicly held companies such as Amedisys, Inc. (NasdaqGS: AMED), Kindred Healthcare, Inc. (NYSE: KND), and LHC Group, Inc. (NasdaqGS: LHCG), and numerous privately held multi-site home care companies, privately held single-site agencies and a significant number of hospital-based agencies. Competition for customers at the local market level is very fragmented and market specific. Generally, each local market has its own competitive profile and no one competitor has significant market share across all our markets. To the best of our knowledge, no individual provider has more than 6% share of the national Medicare home health market.

We believe the primary competitive factors are quality of service and reputation among referral sources. We market our services through our site managers and marketing staff. These individuals contact referral sources in their areas to

market our services. Major referral sources include: physicians, hospital discharge planners, Offices on Aging, social workers, and group living facilities. We also utilize, to a lesser degree, consumer-direct sales, marketing and advertising programs designed to attract customers.

The personal care industry is likewise highly competitive and fragmented. Competitors include home health providers, senior adult associations, and the private hiring of caregivers. We market our services primarily through our site managers, and we compete by offering a high quality of care and by helping families identify and access solutions for care. Major referral sources include case managers, physicians and hospital discharge planners.

Our healthcare innovations segment competes in new industries, some of which were created by the Patient Protection and Affordable Care Act (the "ACA"), signed into law in March 2010. In certain cases, we operate in relatively new and unproven markets which include new competitors that are identified regularly and which range in size from start-up companies to larger publicly held companies like Universal American Corp. (NYSE: UAM). We market our services directly to our customers.

Government Regulation

Medicare Home Health Program

Payment Methodology

As shown in "Compensation for Services" above, approximately 71% of our 2015 consolidated net service revenues were derived from the Medicare Program. Medicare reimburses home health care providers under the Prospective Payment System ("PPS"), which pays a fixed, predetermined rate for services and supplies under an episode of care. An episode of home health care spans a 60-day period, starting with the first day a billable visit is furnished to a Medicare beneficiary and ending 60 days later. If a patient is still in treatment on the 60 th day, a new episode begins on the 61 st day, commonly referred to as a recertification episode, regardless of whether a billable visit is rendered on that day and ends 60 days later.

Payment rates are subject to adjustment based on certain variables including, but not limited to: (a) a case-mix adjustment, which drives the home health resource group ("HHRG") to which the Medicare patient is assigned based on such factors as the patient's clinical, functional, and services utilization characteristics; (b) geographic wage adjustment, including rural rate add-ons, if any; (c) a payment adjustment based upon the level of therapy services required (thresholds set at 6, 14 and 20 visits); (d) a low utilization payment adjustment ("LUPA") if the number of visits was fewer than five; (e) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement at the agency level); (f) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (g) the number of episodes of care provided to a patient; and (h) sequestration, a 2% legislated reduction pursuant to the Budget Control Act ("BCA") signed into law on August 2, 2011, which was effective for episodes ended after March 31, 2013.

In establishing payment rates for the last three years , the Medicare Program re calibrated the national average case-mix levels and maintained budget neutrality by making a corresponding adjustment to the National, Standardized 60-Day Episode Payment Rate ("Base Episode Payment Rate"). These nominal case-mix and payment rate recalibrations result in a lowe r case mix and higher base rates and are intended to have no effect on payments actually made. We have presented the Base Episode Payment Rate established by the Medicare Program for all episodes of care ended on or after

the applicable time periods, along with the Base Episode Payment Rate for each period as if the case-mix reset s were in effect for all prior periods below:

Period	Base Episode Payment Rate (1)	Base Episode Payment Rate Adjusted for Case-mix Recalibrations (2)
January 1, 2016 through December 31, 2016	$ 2,965	$ 2,965
January 1, 2015 through December 31, 2015	2,961	2,990
January 1, 2014 through December 31, 2014	2,869	3,003
January 1, 2013 through December 31, 2013	2,138	3,013

(1) Reflects the payment rates as published by the Medicare Program.
(2) Presents the payment rates on a consistent basis as if the case-mix recalibrations had been in effect for all periods presented. As applicable, a djusted payment rates for each of the years 2013-2015 were calculated by multiplying the actual Base Episode Payment by 1.3464 (2014 Final Rule), then by 1.014 (2015 Final Rule) and then by 1.0097 (2016 Final Rule).

After determining the appropriate PPS payment rate, we record net revenues as services are rendered to patients over the 60-day episode period. At the end of each month, a portion of our revenue is estimated for episodes that have not yet completed, which are generally referred to as episodes in progress. As a result, net service revenues recorded for an episode in progress is subject to change if the actual number of visits differs from the number anticipated at the start of care. Our revenue recognition under the Medicare reimbursement program is discussed in greater detail in Part II, Item 7 "Critical Accounting Policies" and Item 8, "Notes to Consolidated Financial Statements".

Rebasing and Other Statutory Rate Reductions

The Patient Protection and Affordable Care Act (the "ACA"), signed into law in March 2010, has adversely impacted our business and it is reasonable to expect it to have an impact on our business in the future. Specifically, the ACA provisions:

- Outlined annual rate reductions from 2011 through 2017 for Medicare reimbursement rates for home health care services we provide to our patients;
- Established statutory reductions to the annual inflationary rate adjustments we would have otherwise received;
- Established certain "productivity" adjustments reducing the reimbursement rates we would have otherwise received;
- Required Centers for Medicare and Medicaid Services ("CMS") to recalculate or "rebase" home health reimbursement to more closely align with the costs of providing care;
- Limited any reduction in reimbursement rates resulting from "rebasing" to a maximum of 3.5% per year in each of the four phase-in years; and
- Required the Medicare Payment Advisory Commission ("MedPac") and the US Department of Health and Human Services ("HHS") Secretary to assess and report on the impact of rebasing on access and quality of care.

On October 29, 2015, CMS issued its 2016 Home Health Prospective Payment System Rate Update. CMS is implementing a 0.13% increase in the National, Standardized 60-Day Episode Payment Amount consisting of a 2.9% "market basket" increase minus a 0.6% productivity adjustment, a 2.71% ($80.95 per episode) rebasing cut, a 0.97% case mix creep cut and an increase of 1.87% to maintain budget neutrality with respect to recalibration of the home health case mix model for 2016. The impact of recalibration of the case-mix model on the Company results in 2016 will depend upon the Company's actual patient mix in that period. CMS is also implementing a "Value Based Purchasing" (VBP) demonstration in 9 states (including Florida, Tennessee and Massachusetts where the Company generated 38.1% of its fiscal year 2015 revenues) under which certain 2016 agency specific performance measures would be used to establish individual agency reimbursement rates for 2018. CMS estimates that two thirds of providers will be a plus or minus 1.5% adjus tment to 2018 revenue rates. Investors are encouraged to read the rule in its entirety at http://federalregister.gov/a/2015-27931 .

Potential Future Developments in Medicare Home Health

While there have been many changes enacted over the past several years, the Congress and/or CMS may take future actions which could have an adverse impact on our business, including possible:

- Acceleration or compressing of the rebasing period to a period shorter than the currently legislated 2014-2017 four-year phase in;
- Changes in cost sharing between the Medicare program ("Program") and beneficiaries (i.e., co-pays);
- Removal of or changes to codes in the case-mix system or recalibration of the case-mix system including further case-mix creep coding adjustments, all of which could result in changes to rates under the national standardized 60-day episodic payment;
- Post-acute care bundling;
- Removal or reductions to established statutory reductions to the annual inflationary rate adjustments we would have otherwise received;
- "Productivity" payment reductions to reimbursement rates we would have otherwise received;
- Changes that put providers "at risk" for patient outcomes,
- Addition of new pre-authorization requirements for home health services, and
- Other types of changes of which we may not currently be aware.

We are unable to predict when or whether any of these types of changes may be enacted or what impact, if any, they may have on our business.

Medicaid Reimbursement

As shown in "Compensation for Services" above, approximately 22% of our 2015 consolidated net service revenues were derived from state Medicaid and Other Government Programs, with approximately 9. 1 %, 5. 5 %, 3.2% and 1.7 % generated from Medicaid reimbursement programs in the states of Ohio, Connecticut, Tennessee and Kentucky, respectively. Net service revenues under such state programs are derived from services provided under a per visit, per hour or unit basis (as opposed to episodic). Revenues are calculated and recorded using payor-specific or patient-specific fee schedules based on the contracted rates.

The financial condition of the Medicaid programs in each of the states in which we operate is cyclical with some currently facing significant budget issues. States may be expected from time to time to take actions or evaluate taking actions to control the rate of growth of Medicaid expenditures. Among these actions are the following:

- redefining eligibility standards for Medicaid coverage,
- redefining coverage criteria for home and community based care services,
- slowing payments to providers by increasing the minimum time in which payments are made,
- limiting reimbursement rate increases or implementing rate cuts,
- increased utilization of self-directed care alternatives,
- shifting beneficiaries from traditional coverage to Medicaid managed care providers, and
- changing regulations under which providers must operate.

Medicaid programs, while partially federally funded, are administered by the individual states under the broad supervision of CMS. Accordingly, developments typically occur on a state-by-state basis. Specific programs and changes are enacted regularly. Any such changes, if enacted, could adversely impact our operations.

Medicare and Medicaid Reimbursement Summary

The health care industry has experienced, and is expected to continue to experience, extensive and dynamic periods of change. In addition to economic forces and regulatory influences, continuing political debate subjects the health care industry to significant reform. Health care reforms have been enacted as discussed elsewhere in this document and

proposals for additional changes are continuously formulated by departments of the Federal government, Congress, and state legislatures. Such governmental payors provide for approximately 94% of our consolidated net service revenues, including Medicare Advantage plans run by private insurers which are also dependent on federal funding.

We expect legislators and government officials to continuously review and assess alternative health care delivery systems and payment methodologies. Changes in the law or new interpretations of existing laws may have a dramatic effect on the definition of permissible or impermissible activities, the relative cost of doing business, and the methods and amounts of payments for medical care by both governmental and other payors. We expect legislative changes intended to "balance the budget" and slow the annual rate of growth of Medicare and Medicaid to continue. Such future changes may further impact reimbursement for our services. There can be no assurance that future legislation or regulatory changes will not have a material adverse effect on our results of operations.

Governments might take or consider taking further actions because the number of Medicare and Medicaid beneficiaries and their related expenditures are growing at a faster rate than the governments' revenue. Medicare and Medicaid are consuming increasing percentages of budgets and may expand further driven by state based exchanges resulting from the ACA and implementing regulations. Health care financing issues are exacerbated when revenues slow in a down economy. We believe that these financing issues are cyclical in nature rather than indicative of the long-term prospect for Medicare and Medicaid funding of health care services for the populations we serve. Additionally, we believe our services offer the lowest cost alternative to institutional care and are a critical part of the solution to our nation's health care financing problems.

Given the broad and far reaching implications of all the changes in the rapidly evolving environment in which we operate, the incomplete nature of these changes, the pace at which the changes are taking place and the prospects for future changes to be made, we cannot predict the ultimate impact, which may be material and adverse, that health care reform efforts and resulting Medicare and Medicaid reimbursement rates will have on our liquidity, our results of operations, the realizability of the carrying amounts of our intangible assets, including goodwill, or our financial condition. Further, we are unable to predict what effect, if any, such material adverse effect, if it were to occur, might have on our ability to continue to comply with the financial covenants of our revolving credit facility and our ability to continue to access debt capital through that facility.

Permits and Licensure

Many states require companies providing certain health care services to be licensed as home health agencies. In addition, certain health care practitioners employed by us require state licensure and/or registration and must comply with laws and regulations governing standards of practice. The failure to obtain, renew or maintain any of the required regulatory approvals or licenses could adversely affect our business. We believe we are currently licensed appropriately where required by the laws of the states in which we operate. There can be no assurance that either the states or the federal government will not impose additional regulations upon our activities which might adversely affect our results of operations, financial condition, or liquidity.

Certificates of Need

Certain states require companies providing health care services to obtain a certificate of need issued by a state health-planning agency. Where required by law, we have obtained certificates of need from those states. There can be no assurance that we will be able to obtain any certificates of need which may be required in the future, if we expand the scope of our services or if state laws change to impose additional certificate of need requirements, and any attempt to obtain additional certificates of need will cause us to incur certain expenses.

Medicare and Medicaid Participation

Effective March 25, 2011, CMS implemented new enrollment regulations which were a response to aspects of the ACA designed to enhance enrollment procedures to protect against fraud. The regulations authorize the establishment of risk categories with risk level dictating the enrollment screening activities, i.e., more rigorous screening as the perceived risk increases. For Medicare, there are three categories of providers i.e., "limited," "moderate," or "high" risk, and CMS has

placed newly enrolling home health agencies in the "high risk" category, with existing enrolled home health agencies categorized as "moderate risk." In addition to the low risk provider screening procedures, providers in the moderate risk category will be subject to unannounced site visits. For high risk providers, any individual with a 5% or more ownership interest will be subject to fingerprint-based criminal history record checks. Additionally, the new regulations authorize Medicare and state Medicaid agencies to impose temporary enrollment moratoria for a particular type of provider if determined to be necessary to combat fraud, waste, or abuse. To the extent that home health agencies are subject to a moratorium, any newly enrolling home health agency, including any change of ownership subject to the 36 month rule, and any expansion to add a branch would be affected by the moratorium.

Other Regulations

A series of laws and regulations dating back to the Omnibus Budget Reconciliation Act of 1987 ("OBRA 1987") and through the ACA and related subsequent legislation have been enacted and apply to us. Changes in applicable laws and regulations have occurred from time to time since OBRA 1987 including reimbursement reductions and changes to payment rules. Changes are also expected to occur continuously for the foreseeable future.

As a provider of services under Medicare and Medicaid programs, we are subject to the Medicare and Medicaid anti-kickback statute and other "fraud and abuse laws." The anti-kickback statute prohibits any bribe, kickback, rebate or remuneration of any kind in return for, or as an inducement for, the referral of Medicare or Medicaid patients. We may also be affected by the Federal physician self-referral prohibition, known as the "Stark" law, which, with certain exceptions, prohibits physicians from referring patients to entities in which they have a financial interest or from which they receive financial benefit. Penalties for violations of the federal Stark law include payment sanctions, civil monetary penalties, and/or program exclusion. Many states in which we operate have adopted similar self-referral laws, as well as laws that prohibit certain direct or indirect payments or fee-splitting arrangements between health care providers, if such arrangements are designed to induce or to encourage the referral of patients to a particular provider.

As a result of the Health Insurance Portability and Accountability Act of 1996 and other legislative and administrative initiatives, Federal and state enforcement efforts against the health care industry have increased dramatically, subjecting all health care providers to increased risk of scrutiny and increased compliance costs.

We are subject to routine and periodic surveys, audits and investigations by various governmental agencies. In addition to surveys to determine compliance with the conditions of participation, CMS has engaged a number of contractors (including Fiscal Intermediaries, Recovery Audit Contractors, Program Safeguard Contractors, Zone Program Integrity Contractors, and Medicaid Integrity Contributors) to conduct audits to evaluate billing practices and identify overpayments. In addition to audits by CMS contractors, individual states are implementing similar programs such as using Medicaid Recovery Audit Contractors. We believe that we are in material compliance with applicable laws. However, we are unable to predict what additional government regulations, if any, affecting our business may be enacted in the future, how existing or future laws and regulations might be interpreted or whether we will be able to comply with such laws and regulations either in the markets in which we presently conduct, or wish to commence, business.

Medicare Accountable Care Organizations (ACOs)

The ACA also established ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service ("FFS") program, also known as "Original Medicare." The Medicare FFS program covers approximately 70% of the Medicare recipients or approximately 36 million eligible Medicare beneficiaries. ACOs are groups of doctors and other healthcare providers working together to provide high quality services and care for their patients. Provider and beneficiary participation in an ACO is purely voluntary and Medicare beneficiaries retain their current ability to seek treatment from any provider they wish. ACOs are legal entities that contract with CMS for three-year periods. Beneficiaries are assigned to ACOs using an "attribution" model based on a plurality of services provided by the primary care physician. Beneficiaries still have the right to use any doctor or hospital who accepts Medicare, at any time. In order to receive revenues from CMS under the MSSP, the ACO must meet certain minimum savings rates (i.e. save the federal government money) and meet certain quality measures. More specifically, the ACOs costs of medical expenses for its members during a relevant measurement year must be below the ACOs benchmark by a minimum amount as established by CMS for such ACO.

CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating, participating in or contracting with an ACO. The MSSP is designed to improve beneficiary outcomes and increase value of care by (1) promoting accountability for the care of Medicare FFS beneficiaries; (2) requiring coordinated care for all services provided under Medicare FFS; and (3) encouraging investment in infrastructure and redesigned care processes. The MSSP will reward ACOs that reduce health care costs below their benchmark while also meeting performance standards on quality of care. Under the final MSSP rules, Medicare will continue to pay individual providers and suppliers for specific items and services as it currently does under the FFS payment methodologies. MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO, if the ACO is to receive shared savings or for ACOs that have elected to accept responsibility for losses. An ACO that meets the program's quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below its own medical expenditure benchmark provided by CMS.

Insurance Programs and Costs

We bear significant risk under our large-deductible workers' compensation insurance program and our self-insured employee health program. Under the workers' compensation insurance program, we bear risk up to $400,000 per incident except for the recent Black Stone acquisition that had not yet been folded into our program that has a stop loss of $750,000, after which stop-loss insurance coverage is maintained.

We purchase stop-loss insurance for the employee health plan that places a specific limit, generally $300,000, on our exposure for any individual covered life. The ACA also includes regulatory changes related to employer sponsored health insurance benefit plans, the most significant of which was initially effective for the Company January 1, 2015. However, certain components continue to evolve, be delayed or have additional developments. Management has implemented portions of its procedures and is currently working to evaluate the implications of these changes and to develop appropriate courses of action for the Company. At this time, we are unable to predict the full impact of such changes on our health insurance benefit programs or the costs of such programs to the Company.

Malpractice and general patient liability claims for incidents which may give rise to litigation have been asserted against us by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. We are aware of incidents that have occurred through January 1, 2016 , that may result in the assertion of additional claims. We currently carry professional and general liability insurance coverage (on a claims made basis) for this exposure with no deductible.

We also carry D&O coverage for potential claims against our directors and officers, including securities actions, with deductibles ranging from $1 75 ,000 to $ 5 00,000 per claim.

Total premiums, excluding estimated exposure to claims and deductibles, for all our non-health insurance programs were approximately $4 .8 million for the contract year ended May 31, 2015.

We record estimated liabilities for our insurance programs based on information provided by the third-party plan administrators, historical claims experience, the life cycle of claims, expected costs of claims incurred but not paid, and expected costs to settle unpaid claims. We monitor our estimated insurance-related liabilities and related insurance recoveries on a monthly basis and have recorded amounts due under insurance policies in other current assets, while recording the estimated carrier liability in other current liabilities in our consolidated balance sheets. As facts change, it may become necessary to make adjustments that could be material to our results of operations and financial condition.

We believe that our present insurance coverage is adequate. As part of our on-going risk management, regulatory compliance and cost control efforts, we continually seek alternatives that might provide a different balance of cost and risk, including potentially accepting additional self-insurance risk in lieu of higher premium costs.

Executive Officers of the Registrant

See Part III, Item 10 of this Form 10-K for information about the Company's executive officers.

Employees and Labor Relations

As of January 1, 2016 , we had approximately 14,200 employees. None of our employees are represented by a labor organization. We believe our relationship with our employees is satisfactory.

ITEM 1A. RISK FACTOR S

Described below and elsewhere in this report are risks, uncertainties and other factors that can adversely affect our business, results of operations, cash flow, liquidity or financial condition. Investing in our common stock involves a degree of risk. You should consider carefully the following risks, as well as other information in this filing and the incorporated documents before investing in our common stock.

Risks Related to Our Industry

Complying with health care reform legislation and the implementing regulations and programmatic guidelines could have a material adverse impact on our results of operations or financial condition in ways not currently anticipated by us.

Part I, Item 1, "Government Regulation" summarizes US health care reform activities pertinent to our operations. Very often, sweeping new legislation is followed by subsequent legislation to address previously unanticipated consequences, or to further define provisions that were too vague to implement based on the language of the original legislation and by legal actions to challenge its constitutionality. In our view it is reasonable to expect this to occur over the next few years. As a result of the broad scope of the ACA and related legislation, the significant changes it will effect in the healthcare industry and society generally, and the complexity of the technical issues it addresses, we are unable to predict, at this time, all the ramifications the ACA and the implementing regulations may have on our business as a health care provider or a sponsor of an employee health insurance benefit plan. The ACA and implementing regulations and programmatic guidelines could have a material adverse impact on our results of operations or financial condition in ways not currently anticipated by us.

Additionally, we may be unable to take actions to mitigate any or all of the negative implications of the ACA and implementing regulations or programmatic guidelines which may result in unfavorable earnings, losses, or impairment charges.

The ACA and related subsequent legislation may be modified through future legislative action or judicial challenge. We can provide you with no assurance that the ultimate outcome of the ACA, health care reform efforts and/or the federal budget and resulting Medicare reimbursement rates will not have a material adverse effect on our liquidity, our results of operation, the realizability of the carrying amounts of our intangible assets, including goodwill, or our financial condition. Further, we are unable to predict what effect, if any, such material adverse effect, if it were to occur, might have on our ability to continue to comply with the financial covenants of our revolving credit facility and our ability to continue to access debt capital through that facility.

The current status of Federal and State budgets may have a material adverse effect on our future results of operations and financial condition, as well as our ability to access credit and capital.

There can be no assurance that Federal and State governments will be able to operate balanced budgets. While the ultimate outcome of these events cannot be predicted, they may have a material adverse effect on the Company. Historic economic conditions, stimulus efforts by the Federal government and costly new programs created by ACA have placed significant strain on Federal and state budgets, many of which are in a deficit position. Efforts to reduce spending at the Federal and/or state levels may result in reductions in reimbursement by Medicare, Medicaid and other third-party payors along with tax increases, which may in turn result in decreased revenue growth and a decrease in our profitability.

Our contractors and suppliers may also be negatively impacted by these conditions and our ability to provide patient care at a lower cost may diminish and reduce our profitability. Future disruptions in the credit and capital markets, if any, may restrict our access to capital. As a result, our ability to incur additional indebtedness to fund acquisitions and operations may be constrained. If the Federal and State budgets ' conditions deteriorate or do not improve, our results of operations or financial condition could be materially and adversely affected.

Our profitability depends principally on the level of government-mandated payment rates. Reductions in rates, or rate increases that do not cover cost increases, may adversely affect our business.

We generally receive fixed payments from Medicare and Medicaid for our services based on the level of care that we provide patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing services. Although current Medicare legislation provides for an annual adjustment of the various payment rates based on the increase or decrease of the medical care expenditure category of the Consumer Price Index, these Medicare payment rate increases may be less than actual inflation or could be eliminated or reduced in any given year. Consequently, if our cost of providing services, which consists primarily of labor costs, is greater than the respective Medicare or Medicaid payment rate, our profitability would be negatively impacted.

If any of our agencies fail to comply with the conditions of participation in the Medicare program, that agency could be terminated from the Medicare program, which would adversely affect our net service revenue and profitability.

Each of our home care agencies must comply with the extensive conditions of participation in the Medicare program. If any of our agencies fail to meet any of the Medicare conditions of participation, that agency may receive a notice of deficiency from the applicable state surveyor. If that agency then fails to institute a plan of correction to correct the deficiency within the correction period provided by the state surveyor, that agency could be terminated from the Medicare program. Additionally, failure to comply with the conditions of participation related to enrollment could result in a deactivation or revocation of billing privileges. To the extent that billing privileges are revoked there is a mandated one to three-year bar to re-enrollment. The failure to pass a site verification visit, for example, could result in a revocation of billing privileges with a mandated two-year bar to re-enrollment. Although the revocation would only immediately affect the particular enrollment subject to the revocation, CMS has indicated that following a revocation it will review the enrollment files for providers under common ownership or control to determine if a similar sanction is warranted for any of the other related providers. Any termination of one or more of our home care agencies from the Medicare program for failure to satisfy the program's conditions of participation could adversely affect our net service revenue and profitability.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

The federal government and the states in which we operate regulate our industry extensively. The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer, and our interactions with patients and the public. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws and regulations, or their interpretations, or the enactment of new laws or regulations could reduce our profitability by:

- increasing our liability;
- increasing our administrative and other costs;
- increasing or decreasing mandated services;
- forcing us to restructure our relationships with referral sources and providers; or
- requiring us to implement additional or different programs and systems.

Violation of the laws governing our operations, or changes in interpretations of those laws, could result in the imposition of fines, civil or criminal penalties, the termination of our rights to participate in federal and state-sponsored programs, the suspension or revocation of our licenses, or claims for damages. If we become subject to material fines or if other sanctions or other corrective actions are imposed on us, we might suffer a substantial reduction in profitability.

We have been and could become the subject of governmental investigations, claims and litigation that could have a material adverse effect on our financial position, results of operation and liquidity.

Over the years, we, and the industry as a whole, have been the subject of civil investigations, and qui tam or "whistleblower" suits relating to its Medicare-reimbursed oper ations. For further discussion , please refer to Part I, "Legal Proceedings" and Part II, Item 8, "Notes to Consolidated Financial Statements". We may become, or unknown to us may already be, the subject of investigations, qui tams, or lawsuits that could have a material adverse effect on our financial position, results of operation and liquidity.

Governmental agencies and their agents, such as the Medicare Administrative Contractors, fiscal intermediaries and carriers, as well as the OIG, CMS and state Medicaid programs, conduct audits of our health care operations. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material adverse effect on our financial position, results of operation and liquidity.

For example, home health providers, including the Company, have received pre-pay Additional Development Requests ("ADR") in addition to Recovery Audit Contractor audits ("RAC") from the Palmetto Government Benefits Administration ("PGBA") as a result of additional CMS funding allocations to the Medicare Administrative Contractors ("MACs") to conduct pre-payment reviews. ADR and RAC audits are both general and focused in nature. The PGBA acts as one of our four fiscal intermediaries, but processes the majority of our claims. We would expect ADR and RAC audits to continue in the future. If such ADR or RAC audits result in reimbursement adjustments, we may suffer reduced profitability. Further, our appeal rights related to such audits may lead to cash flow delays due to significant backlog at the Administrative Law Judge level. ADR and RAC backlog was so significant in the hospital industry that CMS agreed to settle all ADR and RAC denials at $0.6 8 for each dollar denied. There can be no assurances that CMS will settle such claims for home health providers.

If we are unable to maintain relationships with existing patient referral sources or to establish new referral sources, our growth and profitability could be adversely affected.

Our success depends significantly on referrals from physicians, hospitals, case managers and other patient referral sources in the communities that our home care agencies serve, as well as on our ability to maintain good relationships with these referral sources. Our referral sources are not contractually obligated to refer home care patients to us and may refer their patients to other providers. Our growth and profitability depend on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the benefits of home care by our referral sources and their patients. We cannot assure you that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to expand our operations and operate profitably.

We are subject to federal and state laws that govern our financial relationships with physicians and other healthcare providers, including potential or current referral sources.

We are required to comply with federal and state laws, generally referred to as "anti-kickback laws," that prohibit certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to encourage the referral of patients to a particular provider for medical services. We are also required to comply with the "Stark" law s , which places restrictions on physicians who refer patients to entities in which they have a financial interest or from which they receive financial benefit. In addition to the federal anti-kickback and Stark laws, some of the states in which we operate have enacted laws prohibiting certain business relationships between physicians and other providers of healthcare services. We currently have contractual relationships with certain physicians who provide consulting services to our Company. Many of these physicians are current or potential referral sources. Although we believe our physician consultant arrangements currently comply with state and federal anti-kickback and Stark laws, we cannot assure you that courts or regulatory agencies will not interpret these laws in ways that will implicate our physician consultant arrangements. Violations of anti-kickback and similar laws could lead to fines or sanctions, including under the False Claims Act, that may have a material adverse effect on our operations.

We may be subject to substantial malpractice or other similar claims.

The services we offer involve an inherent risk of professional liability and related substantial damage awards. On any given day, we have thousands of nurses, therapists and other direct care personnel driving to and from patients' homes where they deliver medical and other care. Due to the nature of our business, we and the caregivers who provide services on our behalf may be the subject of medical malpractice claims. These caregivers could be considered our agents, and, as a result, we could be held liable for their medical negligence. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business , reputation , or on our ability to attract and retain patients and employees. We maintain malpractice and various other liability insurance or re-insurance policies and are responsible for deductibles and, as applicable, amounts in excess of the limits of our coverage. Although we contract with highly rated carriers, we cannot guarantee collection of amounts expected to be recovered under various insurance or reinsurance policies.

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement from the time we provide services to the time we receive reimbursement or payment for these services. Data submission requirements change from time to time for payors , payments to us may be delayed pending additional data or documentation requests by the fiscal intermediary, or our ability to effectively respond to such requirements may delay our payment cycle. If we have information system problems or issues that arise with Medicare or Medicaid, we may encounter delays in our payment cycle. Such a timing delay may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. System problems, Medicare or Medicaid issues or industry trends may extend our collection period, adversely impact our working capital. Our working capital management procedures may not successfully negate this risk. There are often timing delays when attempting to collect funds from Medicaid programs. Delays in receiving reimbursement or payments from these programs may adversely impact our working capital.

The home health care industry is highly competitive.

Our home health care agencies compete with local and regional home health care companies, hospitals, nursing homes, and other businesses that provide home nursing services, some of which are large established companies that have significantly greater resources than we do. Our primary competition comes from local companies in each of our markets, and these privately-owned or hospital-owned health care providers vary by region and market. We compete based on the availability of personnel; the quality, expertise, and value of our services; and in select instances, on the price of our services. Increased competition in the future from existing competitors or new entrants may limit our ability to maintain or increase our market share. We cannot assure you that we will be able to compete successfully against current or future competitors or that competitive pressures will not have a material adverse impact on our business, financial condition, or results of operations.

Some of our existing and potential new competitors may enjoy greater name recognition and greater financial, technical, and marketing resources than we do. This may permit our competitors to devote greater resources than we can to the development and promotion of services. These competitors may undertake more far-reaching and effective marketing campaigns and may offer more attractive opportunities to existing and potential employees and services to referral sources.

We expect our competitors to develop new strategic relationships with providers, referral sources, and payors, which could result in increased competition. The introduction of new and enhanced service offerings, in combination with industry consolidation and the development of strategic relationships by our competitors, could cause a decline in revenue or loss of market acceptance of our services or make our services less attractive. Additionally, we compete with a number of non-profit organizations that can finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

We expect that industry forces will continue to have an impact on our business and that of our competitors. In recent years, the health care industry has undergone significant changes driven by efforts to reduce costs, and we expect these

cost containment measures to continue in the future. Frequent regulatory changes in our industry, including reductions in reimbursement rates and changes in services covered, have increased competition among home health care providers. If we are unable to react competitively to new developments, our operating results may suffer.

Portions of our Healthcare Innovations segment competes in relatively new and developing markets.

Portions of our Healthc are Innovations segment compete in new and developing markets with new competitors or solutions developed and introduced to the market regularly. Such new products may capture market share more quickly or may have access to more capital than the capital we have allocated for such projects. Our efforts to bring new solutions to the market may prove unsuccessful, may prove to be unprofitable or may prove to be more costly to bring to market than anticipated. Our investments in these activities are highly speculative in nature and subject to loss.

A shortage of qualified registered nursing staff, physical therapists, occupational therapists and other caregivers could adversely affect our ability to attract, train and retain qualified personnel and could increase operating costs.

We rely significantly on our ability to attract and retain caregivers who possess the skills, experience, and licenses necessary to meet the requirements of our patients. We compete for personnel with other providers of health care services. Our ability to attract and retain caregivers depends on several factors, including our ability to provide these caregivers with attractive assignments and competitive benefits and salaries. We cannot assure you that we will succeed in any of these areas. In addition, there are occasional shortages of qualified healthcare personnel in some of the markets in which we operate. As a result, we may face higher costs of attracting caregivers and providing them with attractive benefit packages than we originally anticipated, and if that occurs, our profitability could decline. Finally, although this is currently not a significant factor in our existing markets, if we expand our operations into geographic areas where healthcare providers have historically unionized, we cannot assure you that the negotiation of collective bargaining agreements will not have a negative effect on our ability to timely and successfully recruit qualified personnel. Generally, if we are unable to attract and retain caregivers, the quality of our services may decline, and we could lose patients and referral sources.

Risks Related to Our Business

We depend on government sponsored reimbursement programs with Medicare accounting for the largest portion of our revenues.

For the years ended January 1, 2016, December 31, 2014 and 2013, we received 71% , 72% and 71%, respectively, of our revenue from Medicare. Reductions in Medicare reimbursement have historically and may continue to adversely impact our profitability. Such reductions in payments to us could be caused by:

- administrative or legislative changes to the base episode rate;
- the elimination or reduction of annual rate increases based on medical inflation;
- the imposition by Medicare of co-payments or other mechanisms shifting responsibility for a portion of payment to beneficiaries;
- adjustments to the relative components of the wage index;
- changes to or imposition of regulations impacting our case-mix or therapy thresholds; or
- other adverse changes to the way we are paid for delivering our services.

Our non-Medicare revenues and profitability also are affected by the continuing efforts of third-party payors to contain or reduce the costs of health care by lowering reimbursement rates, narrowing the scope of covered services, increasing case management review of services, and negotiating reduced contract pricing. Any changes in reimbursement levels from these third-party payor sources and any changes in applicable government regulations could have a material adverse effect on our revenues and profitability. We can provide no assurance that we will continue to maintain the current payor or revenue mix.

Our reliance on government sponsored reimbursement programs such as Medicare and Medicaid makes us vulnerable to possible legislative and administrative regulations and budget cut-backs that could adversely affect the number of

persons eligible for such programs, the amount of allowed reimbursements or other aspects of the programs, any of which could materially affect us. In addition, loss of certification or qualification under Medicare or Medicaid programs could materially affect our ability to effectively market our services.

We have a significant dependence on state Medicaid reimbursement programs.

Approximately 2 2 % , 20% and 23% of our fiscal years 2015, 2014 and 2013 revenues, respectively, were derived from state Medicaid and other government programs, many of which currently face significant budget issues. Further, the acquisitions completed by us in 2015 and 2013 increased our dependence on Medicaid reimbursement. Specifically, for the year ended January 1, 2016 , approximately 9.1%, 5.5%, 3.2% and 1.7% of our revenues were generated from Medicaid reimbursement programs in the states of Ohio, Connecticut, Tennessee and Kentucky, respectively and 8.8%, 5.5%, 2.5% and 1.8% for the year ended December 31, 2014 , respectively. Such amounts for Ohio, Connecticut and Kentucky were 11.7%, 7.1% and 2.3%, respectively for the year ended December 31, 2013 .

The financial condition of the Medicaid programs in each of the states in which we operate is cyclical and many may be expected from time to time to take actions or evaluate taking actions to control the rate of growth of Medicaid expenditures. Among these actions are the following:

- redefining eligibility standards for Medicaid coverage,
- redefining coverage criteria for home and community based care services,
- slowing payments to providers by increasing the minimum time in which payments are made,
- limiting reimbursement rate increases,
- increased utilization of self-directed care alternatives,
- shifting beneficiaries from traditional coverage to Medicaid managed care providers, and
- changing regulations under which providers must operate.

States may be expected to address these issues because the number of Medicaid beneficiaries and their related expenditures are growing at a faster rate than the government's revenue. Medicaid is consuming a greater percentage of states' budgets. This issue is exacerbated when revenues slow in a slowing economy. It is possible that the actions taken by the state Medicaid programs in the future could have a significant unfavorable impact on our results of operations, financial condition and liquidity.

Migration of our Medicare beneficiary patients to Medicare managed care providers could negatively impact our operating results.

Historically, we have generated a substantial portion of our revenue from the Medicare fee-for-service market. The Congress continues to allocate significant additional funds and other incentives to Medicare managed care providers in order to promote greater participation in those plans by Medicare beneficiaries. If these increased funding levels have the intended result, the size of the potential Medicare fee-for-service market could decline, thereby reducing the size of our potential patient population, which could cause our operating results to suffer.

Our growth strategy depends on our ability to manage growing and changing operations.

Our business plan calls for significant growth in our business over the next several years. This growth will place significant demands on our management and information technology systems, internal controls, and financial and professional resources. In addition, we will need to further develop our financial controls and reporting systems to accommodate future growth. This could require us to incur expenses for hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems, and expanding our information technology infrastructure. Our inability to manage growth effectively could have a material adverse effect on our financial results.

Our home health growth strategy depends on our ability to develop and to acquire additional agencies on favorable terms and to integrate and operate these agencies effectively. If we are unable to do so, our future growth and operating results could be negatively impacted.

With regard to development, we expect to continue to open agencies in our existing and new markets. Our new agency growth, however, will depend on several factors, including our ability to:

- obtain locations for agencies in markets where need exists;
- identify and hire a sufficient number of sales personnel and appropriately trained home care and other health care professionals;
- obtain adequate financing to fund growth; and
- operate successfully under applicable government regulations.

With regard to acquisitions, we are focusing significant time and resources on the acquisition of home healthcare providers, or of certain of their assets, in targeted markets. We may be unable to identify, negotiate, and complete suitable acquisition opportunities on reasonable terms. We may incur future liabilities related to acquisitions. Should any of the following problems, or others, occur as a result of our acquisition strategy, the impact could be material:

- difficulties integrating personnel from acquired entities and other corporate cultures into our business;
- difficulties integrating information systems;
- the potential loss of key employees or referral sources of acquired companies or a reduction in patient referrals by hospitals from which we have acquired home health care agencies;
- the assumption of liabilities and exposure to undisclosed liabilities of acquired companies;
- the acquisition of an agency with undisclosed compliance problems;
- the diversion of management attention from existing operations;
- difficulties in recouping partial episode payments and other types of misdirected payments for services from the previous owners; or
- an unsuccessful claim for indemnification rights from previous owners for acts or omissions arising prior to the date of acquisition.

CMS has placed certain limitations on the sale or transfer of the Medicare Provider Agreement for any Medicare-certified home health agency that has been in existence for less than 36 months or that has undergone a change of ownership in the last 36 months. This limitation may reduce the number of home health agencies that otherwise would have been available for acquisition and may limit our ability to successfully pursue our acquisition strategy.

We have invested in development stage companies which may require further funding to support their respective business plans, which may ultimately prove unsuccessful.

Through our Imperium acquisition, we provide strategic health management services to ACOs that have been approved to participate in the Medicare Shared Savings Program ("MSSP"). In addition to our ownership interests in ACOs, we also have service agreements with ACOs that provide for sharing of MSSPs received by the ACO, if any. During 2013, we invested $5.8 million in our Imperium acquisition of which $3 million went to fund operations in pursuit of its business plan. In 2015, we also invested $1 .0 million for a noncontrolling interest in NavHealth and $1 3.1 million in Ingenios Health . These investments are highly speculative, are at risk and we may choose to make further investments, all of which may ultimately provide no return and could lead to a total loss of our investment.

ACOs are entities that contract with CMS to serve the Medicare fee-for-service population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved.

CMS made its first MSSP payments to ACOs for the first measurement periods ending December 31, 2013 in the third quarter of 2014, while issuing its second year payments in the third quarter of 2015 . Imperium received a MSSP

payment in the third quarters of 2015 and 2014 for $1.4 million and $1.6 million, respectively, while breaking even for the year at the operating income level.

We expect our Imperium and Ingenios operations to negatively impact our cash flows. Notwithstanding our efforts, our ACOs may be unable to meet the required savings rates or may no t satisfy the quality measures and efforts to drive other revenue may not cover operating costs of these investments. In addition, as the MSSP is a new program, it presents challenges and risks associated with the timeliness and accuracy of data and interpretation of complex rules, which may have a material adverse effect on our ability to recoup any of our investments. Further, there can be no assurance that we will maintain positive r elations with our ACO partners or significant customers, which could result in a loss of our investment.

In addition, CMS, the US Office of Inspector General, the Internal Revenue Service, the Federal Trade Commission, US Department of Justice, and various states have adopted or are considering adopting new legislation, rules, regulations and guidance relating to formation and operation of ACOs. Such laws may, among other things, require ACOs to become subject to financial regulation such as maintaining deposits of assets with the states in which they operate, the filing of periodic reports with the insurance department and/or department of health, or holding certain licenses or certifications in the jurisdictions in which the ACOs operate. Failure to comply with legal or regulatory restrictions may result in CMS terminating the ACOs agreement with CMS and/or subjecting the ACO to loss of the right to engage in some or all business in a state, payments fines or penalties, or may implicate federal and state fraud and abuse laws relating to anti-trust, physician fee-sharing arrangements, anti-kickback prohibitions, prohibited referrals, any of which may adversely affect our operations and/or profitability.

We may require additional capital to pursue our acquisition strategy.

At January 1, 2016, we had cash and cash equivalents of approximately $ 7.5 million and additional borrowing capacity of approximately $32.1 million. Based on our current plan of operations, including acquisitions, we cannot assure you that this amount will be sufficient, nor continue to be fully available, to support our current growth strategies. We cannot readily predict the timing, size, and success of our acquisition efforts and the associated capital commitments. If we do not have sufficient cash resources, our growth could be limited unless we obtain additional equity or debt financing.

We last issued additional shares of our common stock in the third quarter of 2009, other than in conjunction with acquisitions in 2015 and 2013 and employee benefit plans. At some future point, we may elect to issue additional equity or debt securities in conjunction with raising capital or completing an acquisition. We cannot assure you that such issuances will not be dilutive to existing shareholders. Conversely, our board may approve stock repurchase programs in the future, which may use funds previously otherwise available for the pursuit of growth.

Our business depends on our information systems. Our inability to effectively integrate, manage, and keep secure our information systems could disrupt our operations.

Our business depends on effective and secure information systems that assist us in, among other things, monitoring utilization and other cost factors, processing claims, reporting financial results, measuring outcomes and quality of care, managing regulatory compliance controls, and maintaining operational efficiencies. These systems include software developed in-house and systems provided by external contractors and other service providers. To the extent that these external contractors or other service providers become insolvent or fail to support the software or systems, our operations could be negatively affected. Our agencies also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, payroll, learning management and other information. If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to process transactions and produce timely and accurate reports could be adversely affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Our acquisitions require transitions and integration of various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain, or expand our systems properly, we could

suffer from, among other things, operational disruptions, regulatory problems, working capital disruptions and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in our services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of patients if security breaches are not prevented.

Further, our information systems are vulnerable to damage or interruption from fire, flood, natural disaster, power loss, telecommunications failure, break-ins and similar events. A failure to implement our disaster recovery plans or ultimately restore our information systems after the occurrence of any of these events could have a material adverse effect on our business, financial condition and results of operations.

Because of the confidential health information we store and transmit, loss of electronically-stored information for any reason could expose us to a risk of regulatory action, litigation, reputation damage, possible liability and loss.

We face additional federal requirements in the transmission and retention and protection of health information.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was enacted to ensure that employees can retain and at times transfer their health insurance when they change jobs and to simplify healthcare administrative processes. The enactment of HIPAA expanded protection of the privacy and security of personal medical data and required the adoption of standards for the exchange of electronic health information. Among the standards that the Secretary of Health and Human Services has adopted pursuant to HIPAA are standards for electronic transactions and code sets, unique identifiers for providers, employers, health plans and individuals, security and electronic signatures, privacy and enforcement. Failure to comply with HIPAA could result in fines and penalties that could have a material adverse effect on us.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), effective February 22, 2010, sets forth health information security breach notification requirements. The HITECH Act requires patient notification for all breaches, media notification of breaches of over 500 patients and at least annual reporting of all breaches to the Secretary of HHS. The HITECH Act also includes 4 tiers of sanctions for breaches ($100 to $1.5 million). Failure to comply with HITECH could result in fines and penalties that could have a material adverse effect on us.

We develop portions of our clinical software system in-house. Failure of, or problems with, our system could harm our business and operating results.

We develop and utilize a proprietary clinical software system to collect assessment data, log patient visits, generate medical orders, and monitor treatments and outcomes in accordance with established medical standards. The system integrates billing and collections functionality as well as accounting, human resource, payroll, and employee benefits programs provided by third parties. Problems with, or the failure of, our technology and systems could negatively impact data capture, billing, collections, and management and reporting capabilities. Any such problems or failures could adversely affect our operations and reputation, result in significant costs to us, and impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems may be substantial and could adversely affect our profitability.

We depend on outside software providers.

We depend on the proper functioning and availability of our information systems in operating our business, some of which are provided and/or hosted by outside software providers. These information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. If our providers are unable to maintain or expand our information systems properly, we could suffer from operational disruptions and an increase in administrative expenses, among other things. The regulatory environment related to information security and privacy is evolving and increasingly demanding. Furthermore, we also rely on cloud computing and other similar hosted technologies that result in third parties holding significant amounts of customer or employee information on our behalf. If the security and information systems of our or of outsourced third party providers we use to store or process such information are compromised or if we, or such third parties, otherwise fail to comply with applicable laws and regulations, we could face litigation and the imposition of penalties that could adversely affect our financial performance. Our reputation as a brand or as an employer could also be adversely affected from security breaches or regulatory violations, which could impair our sales or ability to attract and keep qualified employees.

Our insurance coverage may not be sufficient for our business needs and/or the cost of such coverage may adversely impact our results of operations.

We bear significant insurance risk under our large-deductible workers' compensation insurance program and our self-insured employee health program. We also carry D&O coverage for potential claims against our directors and officers, including securities actions. For additional information, please refer to Part I, Item 1, "Insurance Programs and Costs" and Part II, Item 8, "Notes to Consolidated Financial Statements." Claims made to date or in the future may exceed the limits of such insurance, if any. Such claims, if successful and in excess of such limits, could have a material adverse effect on our ability to conduct business or on our assets. Benefits provided by our employer sponsored health insurance plan may require changes as a result of the ACA or other regulatory action. Such changes may have an adverse impact on our operating results.

Our insurance coverage also includes fire, property damage, and general liability with varying limits. Although we maintain insurance consistent with industry practice, we cannot assure you that the insurance we maintain will satisfy claims made against us. In addition, as a result of operating in the home healthcare industry, our business entails an inherent risk of claims, losses , and potential lawsuits alleging employee accidents that may occur in a patient's home. Finally, insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms. Any claims made against us, regardless of their merit or eventual outcome, could damage our reputation and business.

We estimate Medicare and Medicaid liabilities that may be payable by us in the future. These liabilities may be subject to audit or further review, and we may owe additional amounts beyond what we expect and have reserved.

The Company is paid for its services primarily by federal and state third-party reimbursement programs, commercial insurance companies, and patients. Revenues are recorded at established rates in the period during which the services are rendered. Appropriate allowances are recorded when the services are rendered, if necessary, to give recognition to third party payment arrangements.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. It is common for issues to arise related to: 1) medical coding, particularly with respect to Medicare, 2) patient eligibility, particularly related to Medicaid, and 3) other reasons unrelated to credit risk, all of which may result in adjustments to recorded revenue amounts. Management continuously evaluates the potential for revenue adjustments and when appropriate provides allowances for losses based upon the best available information. There is at least a reasonable possibility that recorded estimates could change by material amounts in the near term.

We depend on the services of our executive officers and other key employees.

Our success depends upon the continued employment of certain members of our senior management team, including our Chairman and Chief Executive Officer, William B. Yarmuth, and our other named executive officers. We also depend

upon the continued employment of the individuals that manage several of our key functional areas, including operations, business development, accounting, finance, human resources, marketing, information systems, contracting and compliance. The departure of any member of our senior management team or inability to appropriately implement succession plans may materially affect our operations.

Our operations could be affected by natural disasters.

A substantial number of our agencies are located in Florida or coastal regions in the northeast, increasing our exposure to hurricanes and other natural disasters. The occurrence of natural disasters in the markets in which we operate could not only affect the day-to-day operations of our agencies but also could disrupt our relationships with patients, employees and referral sources located in the affected areas. In addition, any episode of care that is not completed due to the impact of a natural disaster will generally result in lower revenue for the episode. We cannot assure you that hurricanes or other natural disasters will not have a material adverse impact on our business, financial condition or results of operations in the future.

Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile and this may adversely affect our stockholders.

The price at which our common stock trades may be volatile. The stock market has from time to time experienced significant price and volume fluctuations that have affected the market prices of securities, particularly securities of health care companies. The market price of our common stock may be influenced by many factors, including:

- our operating and financial performance;
- variances in our quarterly financial results compared to expectations;
- the depth and liquidity of the market for our common stock;
- future sales of common stock or the perception that sales could occur;
- investor perception of our business and our prospects;
- developments relating to litigation or governmental investigations;
- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters; or
- general industry, economic and stock market conditions.

In addition, the stock market in general has experienced price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of health care provider companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. In the past, securities class-action litigation has often been brought against companies following periods of volatility in the market price of their respective securities. We may become involved in this type of litigation in the future. Litigation of this type is often expensive to defend and may divert our management team's attention as well as resources from the operation of our business.

Sales of substantial amounts of our common stock, or the availability of those shares for future sale, could adversely affect our stock price and limit our ability to raise capital.

At January 1, 2016 , outstanding shares of our common stock totaled 10,021,395. In 2013, we established the 2013 Stock and Incentive Compensation Plan for the benefit of employees and directors providing for the issuance of up to 700,000 shares of common stock. As of January 1, 2016 , shares of our common stock remained reserved for issuance pursuant to our incentive compensation plans totaled 373,615 and shares of our common stock reserved for issuance pursuant to our employee stock purchase plan totaled 300,000. The market price of our common stock could decline as a result of sales of substantial amounts of our common stock to the public or the perception that substantial sales could occur. These sales also may make it more difficult for us to sell common stock in the future to raise capital.

We do not regularly pay dividends on our common stock and you should not expect to receive dividends on shares of our common stock.

Although our board of directors declared a special cash dividend of $2.00 per common share to shareholders of record on December 20, 2012, we do not regularly pay dividends and intend to retain all future earnings to finance the continued growth and development of our business. In addition, we do not anticipate paying any cash dividends on our common stock in the foreseeable future. Any future payment of cash dividends will depend upon our financial condition, capital requirements, earnings, and other factors deemed relevant by our board of directors.

Our Board of Directors may use anti-takeover provisions or issue stock to discourage control contests.

We have implemented anti-takeover provisions or provisions that could have an anti-takeover effect, including advance notice requirements for director nominations and stockholder proposals. These provisions, and others that the Board of Directors may adopt hereafter, may discourage offers to acquire us and may permit our Board of Directors to choose not to entertain offers to purchase us, even if such offers include a substantial premium to the market price of our stock. Therefore, our stockholders may be deprived of opportunities to profit from a sale of control.

ITEM 1B. UNRESOLVED STAFF COMMENT S

NONE.

ITEM 2. PROPERTIE S

Our executive offices are located in Louisville, Kentucky, in approximately 33,000 square feet of space leased from an unaffiliated party.

We have 274 real estate location leases ranging from approximately 100 to 33,000 square feet of space in their respective locations. See Part I, Item 1, "Business - Operating Segments" and Part II, Item 8, "Notes to Consolidated Financial Statements." We believe that our facilities are adequate to meet our current needs, and that additional or substitute facilities will be available if needed.

ITEM 3. LEGAL PROCEEDING S

From time to time, we are subject to various legal actions arising in the ordinary course of our business, including claims for damages for personal injuries. In our opinion, after discussion with legal counsel, the ultimate resolution of any of these pending ordinary course claims and legal proceedings will not have a material effect on our financial position or results of operations.

The Company is in the process of complying with a civil subpoena from the United States Department of Justice received in January of 2016 related to two locations acquired along with SunCrest in late 2013. SunCrest had previously acquired the locations in its merger with Omni Home Health in 2011. The subpoena seeks the production of various pre-acquisition business records limited to certain Omni operations in Sarasota and Tampa, Florida for the years 2007-2011. The Company is cooperating fully with this investigation. The subject operations generated less than 1% of the Company's consolidated revenues in 2015.

ITEM 4. MINE SAFETY DISCLOSURE S

Not applicable.

PART I I

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUIT Y, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our common stock is traded on the NASDAQ Global Select market under the symbol "AFAM" Set forth below are the high and low sale prices for the common stock for the periods indicated as reported by NASDAQ:

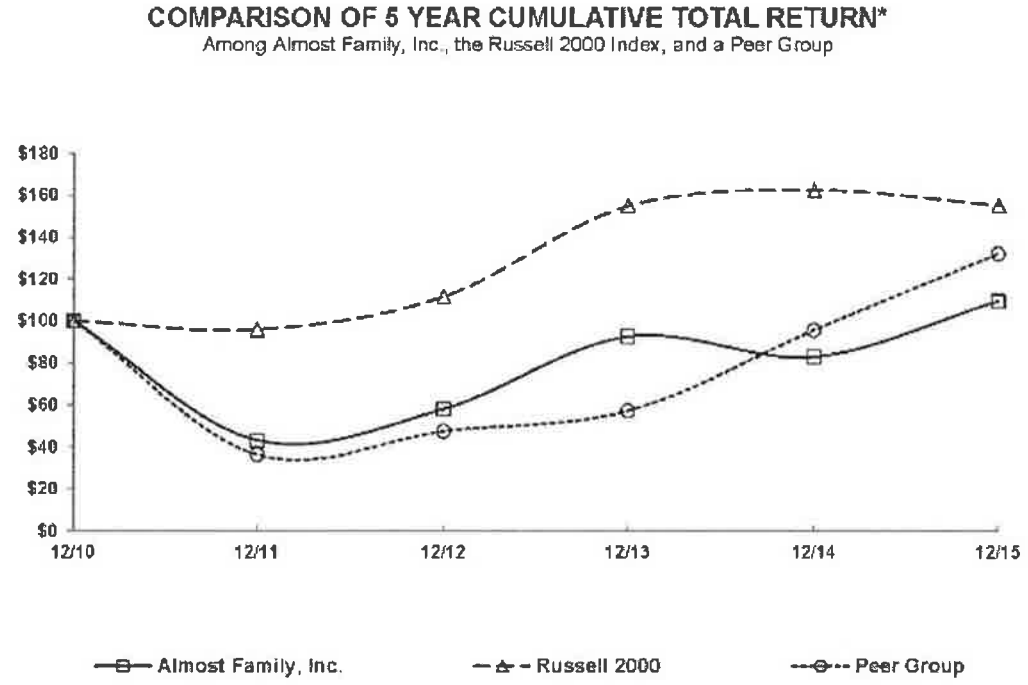
Closing Common Stock Prices Quarter Ended:	High	Low
January 1, 2016	44.70	37.75
October 2, 2015	49.74	39.14
July 3, 2015	47.76	36.59
April 3, 2015	46.55	28.68
December 31, 2014	30.30	26.35
September 30, 2014	28.76	22.47
June 30, 2014	24.29	19.98
March 31, 2014	33.27	22.21

On March 1, 2016, the last reported sale price for the common stock reported by NASDAQ was $ 39.08 and there were approximately 312 holders of record of our common stock. We did not pay dividends in 2015 or 2014. We do not intend to pay additional dividends on our common stock and will retain our earnings for future operations and the growth of our business.

STOCK PERFORMANCE GRAPH

The following stock performance graph does not constitute soliciting material and should not be deemed filed or incorporated by reference into any other Company filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except to the extent the Company specifically incorporates the performance graph by reference therein.

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.10 par value per share, for the five-year period ended January 1, 2016 , with the cumulative total return on the Russell 2000 index and an industry peer group over the same period (assuming the investment of $100 in each on December 31, 2010 and the reinvestment of dividends, if any). The peer group we selected is comprised of: Amedisys, Inc. (AMED) and LHC Group, Inc. (LHCG). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance.



*$100 invested on 12/31/10 in stock or index, including reinvestment of dividends.
Fiscal year ending December 31.

	12/10	12/11	12/12	12/13	12/14	12/15
Almost Family, Inc.	**100**	**43.15**	**57.98**	**92.52**	**82.85**	**109.40**
Russell 2000	**100**	**95.82**	**111.49**	**154.78**	**162.35**	**155.18**
Peer Group	**100**	**36.30**	**47.33**	**57.19**	**95.63**	**132.01**

ITEM 6. SELECTED FINANCIAL DAT A

The following table sets forth selected financial information derived from the consolidated financial statements of the Company for the periods and at the dates indicated. The information should be read in conjunction with the consolidated financial statements and related notes included elsewhere in this and prior year Form 10-Ks.

(In thousands except per share data)	Fiscal Year ended January 1, 2016 (1)	Calendar Year 2014	2013	2012	2011
Results of operations data:					
Net service revenues	$ 532,214	$ 495,829	$ 356,912	$ 340,620	$ 329,644
Income from continued operations attributable to Almost Family, Inc.	$ 20,009	$ 13,763	$ 8,784	$ 16,802	$ 19,337
Discontinued operations	—	—	(558)	482	1,465
Net income attributable to Almost Family, Inc.	$ 20,009	$ 13,763	$ 8,226	$ 17,284	$ 20,802
Per share:					
Basic:					
Number of shares	9,505	9,333	9,279	9,285	9,278
Income from continued operations attributable to Almost Family, Inc.	$ 2.11	$ 1.47	$ 0.95	$ 1.81	$ 2.08
Discontinued operations	—	—	(0.06)	0.05	0.16
Net income attributable to Almost Family, Inc.	$ 2.11	$ 1.47	$ 0.89	$ 1.86	$ 2.24
Diluted:					
Number of shares	9,745	9,462	9,374	9,324	9,360
Income from continued operations attributable to Almost Family, Inc.	$ 2.05	$ 1.45	$ 0.94	$ 1.80	$ 2.07
Discontinued operations	—	—	(0.06)	0.05	0.16
Net income attributable to Almost Family, Inc.	$ 2.05	$ 1.45	$ 0.88	$ 1.85	$ 2.22
Dividend declared per share	$ —	$ —	$ —	$ 2	$ —

(1) - See page 35 for discussion regarding the Company's change to a 52-53 week reporting calendar in 2015.

	January 1, 2016	December 31, 2014	2013	2012	2011
Balance sheet data					
Working capital	$ 54,643	$ 40,274	$ 44,148	$ 62,541	$ 63,394
Total assets	464,769	345,258	354,362	249,259	251,160
Long-term liabilities	136,048	60,432	83,436	17,846	15,708
Total liabilities	190,869	112,066	136,669	44,944	44,863
Noncontrolling interest-redeemable - Healthcare Innovations	3,639	3,639	3,639	—	—
Stockholders' equity	270,261	229,553	214,054	204,315	206,297

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSI S OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

OVERVIEW

The Company has two divisions, Home Health care and Healthcare Innovations. The Home Health care division is comprised of two reportable segments, Visiting Nurse Services (VN or Visiting Nurse) and Personal Care Services (PC or Personal Care). Our Healthcare Innovations division is also a reporting segment. Reportable segments have been identified based upon how management has organized the business by services provided to customers and the criteria in ASC Topic 280, *Segment Reporting*.

Our VN segment provides skilled medical services in patients' homes largely to enable recipients to reduce or avoid periods of hospitalization and/or nursing home care. VN Medicare revenues are generated primarily on a per episode basis rather than a fee per visit or an hourly basis. Approximately 94% of the VN segment revenues are generated from the Medicare program while the balance is generated from Medicaid and private insurance programs.

Our PC segment services are also provided in patients' homes. These services (generally provided by paraprofessional staff such as home health aides) are generally of a custodial rather than skilled nature. PC revenues are generated primarily on an hourly basis. Approximately 83% of the PC segment revenues are generated from Medicaid and other government programs while the balance is generated from insurance programs and private pay patients.

Our HealthCare Innovations (" HCI ") business segment was created to house and separately report on its developmental activities outside our traditional home health business platform. These activities are intended ultimately, whether directly or indirectly, to benefit patients and payers through the enhanced provision of home health services. Its activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. These include, but are not limited to: technology, information, population health management, risk-sharing, assessments, care coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision making. We believe these activities help us discover valuable insight and experiences that would not otherwise be gained in the routine operation of its core home health business segments. Further, we believe these innovation activities, will play an important role in collaborating with policy makers, payers, providers, and anyone who assumes financial risk for managing patient populations, to seek to reduce costs and improve quality by providing increasingly more care for more patients in their homes than ever before.

The HCI segment now includes: a) Imperium Health Management, an ACO enablement company, b) an investment in NavHealth, a population-health analytics company, c) Ingenios Health, a Nurse-Practitioner-oriented and mobile technology-enabled health risk assessment company primarily serving managed care organizations; and d) Long Term Solutions, an in-home assessment company serving the long-term care insurance industry.

During 2015, we completed four acquisitions and made a cost based investment. On November 5, 2015, we completed the acquisition of Black Stone Operations, LLC ("Black Stone"). Black Stone owned and operated personal care and skilled home health services in western Ohio. On August 29, 2015, we completed the acquisition of Bracor, Inc. (dba "WillCare"). Willcare owned and operated VN and PC branch locations in New York (1 2) and Connecticut (1). On March 1, 2015 we acquired the stock of WillCare's Ohio operations. On July 22, 2015, we acquired Ingenios Health Co. ("Ingenios"). Ingenios is a leading provider of technology enabled in-home clinical assessments for Medicare Advantage, Managed Medicaid and Commercial Exchange lives in 7 states and Washington, D.C. The results of the Black Stone and WillCare acquisitions are reported in our VN and PC segments, while our Ingenios acquisition results are included in the Healthcare Innovations segment.

On January 29, 2015, we acquired a noncontrolling interest in a development stage analytics and software company, NavHealth, Inc. ("NavHealth"). The investment is an asset of our Health care Innovations segment.

During the second quarter of 2014, we acquired a small home health agency in southern Kentucky using cash on hand to expand existing VN segment operations. During 2013, we completed three acquisitions. On December 6, 2013, the Company completed the acquisition of Omni Home Health Holdings, Inc. ("SunCrest"). SunCrest subsidiaries owned

and operated 60 Medicare-certified home health agencies and 9 private duty agencies in Florida, Tennessee, Georgia, Pennsylvania, Kentucky, Illinois, Indiana, Mississippi and Alabama. On October 4, 2013, we acquired a controlling interest in Imperium Health Management, LLC ("Imperium"), a development-stage enterprise that provides strategic health management services to Accountable Care Organizations ("ACOs"). On July 17, 2013, the Company acquired the assets of the Medicare-certified home health agencies owned by Indiana Home Care Network ("IHCN"). The results of operations for SunCrest and IHCN are principally reported within the Company's Visiting Nurse reportable segment, while Imperium results are included in the Healthcare Innovations segment.

Our View on Reimbursement and Diversification of Risk

Our Company is highly dependent on government reimbursement programs which pay for the majority of the services we provide to our patients. Reimbursement under these programs, primarily Medicare and Medicaid, is subject to frequent changes as policy makers balance their own needs to meet the health care needs of constituents while also meeting their fiscal objectives. Medicare and Medicaid are consuming a greater percentage of federal and states' budgets, respectively, which is exacerbated in times of economic downturn. We believe that these financial issues are cyclical in nature rather than indicative of the long-term prospect for Medicare and Medicaid funding of health care services. Additionally, we believe our services offer the lowest cost alternative to institutional care and is a part of the solution to both balancing the federal budget and the states' Medicaid financing problems.

We believe that an important key to our historical success and to our future success is our ability to adapt our operations to meet changes in reimbursement as they occur. One important way in which we have achieved this adaptability in the past, and in which we plan to achieve it in the future, is to maintain some level of diversification in our business mix.

The execution of our business plan will place primary emphasis on the development of our home health operations. As our business grows , we may evaluate opportunities for the provision of other health care services in patients' homes that would be consistent with our Senior Advocacy mission.

Our Business Plan

Our future success depends on our ability to execute our business plan. Over the next three to five years we will try to accomplish the following:

- Generate meaningful same store sales growth through the focused provision of high quality services and attending to the needs of our patients;
- Drive our costs down, while continuing to provide high-quality patient care, by improving the productivity of our work force through improved monitoring, tighter controls, workflow automation, use of technology and other opportunities for efficiency gains;
- Expand the significance of our home health services by selectively acquiring other quality providers, through the startup of new agencies and potentially by providing new services in patients' homes consistent with our Senior Advocacy mission;
- Make additional strategic investments which expand our Healthcare Innovation segment in its mission to find solutions for more effective, efficient and appropriate delivery of homecare; and
- Expand our capital base through both earnings performance and by seeking additional capital investments in our Company.

Health Care Reform Legislation and Medicare Regulations

The Federal Government has been pursuing a comprehensive reform of the US healthcare system since early 2009. Numerous changes have been enacted, proposed and continue to be debated, which are discussed in more detail in Part I, Item 1, "Government Regulation" and Part I, Item 1A, "Risk Factors." Many of the change provisions do not take

effect for an extended period of time and most will require the publication of implementing regulations and/or the issuance of programmatic guidelines.

It is reasonable to expect that the implementation of the ACA and other changes and potential changes described in Part I, Item 1, Government Regulation, might have a more immediate and negative impact on those providers generating lower margins than us, with more leverage relative to earnings than us, with less capital resources than us, or with less ability to adapt their operations. We believe this may result in a contraction of the number of home health providers. In the event of such a contraction in the number of providers, we believe the surviving providers may benefit from a higher rate of admissions growth than would have otherwise occurred. Those surviving providers may earn incremental margins on those higher admissions that may serve to offset a portion of the rate reduction from the Medicare program. However, there can be no assurance that we will be successful in attracting such higher admissions.

It is also reasonable to expect that future rate cuts will present additional opportunities for us to make acquisitions of other providers at valuations and on terms that are attractive to us and enable us to spread our segment and unallocated corporate overhead expenses across a larger business base. However, there can be no assurance that we will be successful in making such acquisitions or that such opportunities will present themselves.

As a result of the broad scope of health care reform, the significant changes it will effect in the healthcare industry and society generally, and the complexity of the technical issues it addresses, we are unable to predict, at this time, all the ramifications health care reform may have on our business as a health care provider or a sponsor of an employee health insurance benefit plan. These matters could have a material adverse impact on our results of operations or financial condition in ways not currently anticipated by us. This may increase our costs, decrease our revenues, expose us to expanded liability or require us to revise the ways in which we conduct our business. Refer to the results of operations for the impact of these items on revenue, operating and net income for the years ended January 1, 2016, December 31, 2014 and 2013.

Management is continuing its work to evaluate the implications of these changes and to develop appropriate courses of action for the Company. Additionally, we may be unable to take actions to mitigate any, or all, of the negative implications of these matters.

We contemplate formulating and taking actions intended to mitigate or otherwise offset some of the negative effects of reimbursement changes. These actions may include any or all of the following:

- Attempting to increase our revenues by: investing more resources in sales and marketing activities, development of diagnosis related specialty programs and increasing our educational programs regarding the value of home health to drive admission growth, establishing startup branch operations to expand our service territories, and acquisitions of underperforming providers with strong referral relationships,
- Attempting to reduce our costs by: developing a more efficient delivery model, increasing the productivity standards for our staff, optimizing the appropriate use of different levels of professional staff, limiting or eliminating the growth in wage rates, limiting or reducing the size of our work force, closing unprofitable branch operations and accelerating our efforts to evaluate the use of various technological approaches to the delivery of patient care to improve patient outcomes and/or improve the productivity of our workforce,
- Evaluating the potential implications of health care reform on our employee benefit plans, and possible changes we may need to make to our plans, and
- Potentially other actions we deem appropriate including evaluation of potential additional service offerings in patients' homes consistent with our Senior Advocacy mission or changing the mix of the types of services we provide.

Although we will attempt to mitigate or otherwise offset the negative effect of health care reform on our revenue and our employee benefit plans, our actions may not ultimately be cost effective or prove successful.

Seasonality

Our Visiting Nurse segment operations located in Florida (which generated approximately 2 4 % of that segment's revenues in fiscal year 2015) normally experience higher admissions during the first quarter and lower admissions during the third quarter than in the other quarters due to seasonal population fluctuations.

Fiscal Year End

Effective with the first quarter of 2015, the Company adopted a 52-53 week fiscal reporting calendar under which it will report its annual results going forward in four equal 13-week quarters. Every fifth year, one quarter will include 14 weeks and that year will include 53 weeks of operating results. Once fully adopted, this approach will minimize the impact of calendar differences when comparing different historical periods.

As a result of the change in the fiscal reporting calendar, fiscal year 2015 ended January 1, 2016 also included the New Year's Day holiday observed January 1, 2016. As such the fiscal year ended January 1, 2016 is 366 days, one more day than it would have been if the change had not been made which reduced diluted earnings per share by $0.03.

Critical Accounting Policies

The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States. When more than one accounting principle, or the method of its application, is generally accepted, we select the principle or method that is appropriate in the specific circumstances. Application of these accounting principles requires us to make estimates about the future resolution of existing uncertainties; actual results could differ from these estimates. We evaluate our estimates, including those related to revenue recognition, collectability of accounts receivable, insurance reserves, goodwill, intangibles, income taxes, stock-based compensation, litigation, and contingencies on an on-going basis. We base these estimates on our historical experience and other assumptions that we believe are appropriate under the circumstances. In preparing these consolidated financial statements, we have made our best estimates and judgments of the amounts and disclosures included in the consolidated financial statements.

Revenue Recognition

We recognize revenues when patient services are provided, primarily in our patients' homes. Net service revenues are stated at amounts estimated by us to be their net realizable values. We are paid for our services primarily by federal and state third-party reimbursement programs and, to a lesser degree, commercial insurance companies and patients.

Medicare Episodic Revenues

Approximately 71% of our consolidated net service revenues are derived from the Medicare program. Net service revenues are recorded under the Medicare prospective payment program ("PPS") based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) changes in the base episode payments established by the Medicare program; (b) adjustments to the base episode payments for case-mix and geographic wages; (c) a low utilization payment adjustment ("LUPA") if the number of visits was fewer than five; (d) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (e) a payment adjustment based upon the level of therapy services required (thresholds set at 6, 14 and 20 visits); (f) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement at the agency level); (g) the number of episodes of care provided to a patient; and (h) 2% sequestration reduction for episodes ending after March 31, 2013.

At the beginning of each Medicare episode, we calculate an estimate of the amount of expected reimbursement based on the variables outlined above and recognize Medicare revenue on an episode-by-episode basis during the course of each episode over its expected number of visits. Over the course of each episode, as changes in the variables become known, we calculate and record adjustments as needed to reflect changes in expectations for that episode from those established at the start of the 60 day period until its ultimate outcome at the end of the 60 day period is known.

Non-Medicare Revenues

Substantially all remaining revenues are derived from services provided under a per visit, per hour or unit basis (as opposed to episodic) for which revenues are calculated and recorded using payor-specific or patient-specific fee schedules based on the contracted rates in each third party payor agreement.

Contingent Service Revenues

Our Healthcare Innovations segment provides strategic health management services to ACOs that have been approved to participate in the "MSSP." In addition to having ownership interests in a few ACOs, we also have service agreements with ACOs that provide for sharing of MSSP payments received by the ACO, if any. ACOs are entities that contract with Centers for Medicare and Medicaid Services (CMS) to serve the Medicare fee-for-service population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. The MSSP is relatively new and therefore has limited historical experience, which impacts the Company's ability to accurately accumulate and interpret the data available for calculating an ACOs' shared savings, if any. MSSP payments are not recognized in revenue until persuasive evidence of an arrangement exists, services have been rendered, the payment is fixed and determinable and collectability is assured, which generally is satisfied only upon cash receipt. Under such agreements, we recognized $1.4 million in MSSP payments for cash received during 2015 related to savings generated for the program period ended December 31, 2014 and $1.6 million for savings generated for the program period ended December 31, 2013, which accounted for 41% and 63%, respectively of our healthcare innovations segment revenues. No revenue has been recognized related to MSSP payments for savings generated through December 31, 2015, if any.

Revenue Adjustments

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, we may adjust previously recorded revenue amounts due to issues related to: a) medical coding, particularly with respect to Medicare, b) patient eligibility, particularly with respect to Medicaid, and c) other reasons unrelated to credit risk. Revenue adjustments, if any, to reflect actual payment amounts for completed episodes or services provided under per visit, per hour or unit basis which differ from our estimates or audit adjustments are recorded when known and estimable. Historically, revenue adjustments have not been significant and as such, we believe that net service revenues and accounts receivable - net reflect their net realizable value. Changes in estimates related to prior periods (increased) decreased revenues by approximately ($365,000), ($320,000) and $114,000 in the years ended January 1, 2016 and December 31, 2014 and 2013, respectively.

Accounts Receivable

Accounts receivable are reported at their estimated net realizable value and are net of estimated allowances for uncollectible accounts and adjustments. Accounts receivable consist primarily of amounts due from third-party payors and patients. We evaluate the collectability of our accounts receivable based on certain factors, such as payor types, historical collection trends and aging categories. We calculate our reserve for uncollectible accounts based on the length of time that the receivables are past due. The percentage applied to the receivable balances for each payor's various aging categories is based on historical collection experience, business and economic conditions and reimbursement trends.

Insurance Programs

We bear significant risk under our large-deductible workers' compensation insurance program and our self-insured employee health program. Under the workers' compensation insurance program, we bear risk up to $400,000 per incident, except for an acquisition that has not been folded into our program and carries a stop-loss of $750,000. We purchase stop-loss insurance for the employee health plan that places a specific limit, generally $300,000, on our exposure for any individual covered life.

Malpractice and general patient liability claims for incidents which may give rise to litigation have been asserted against us by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. We are aware of incidents that have occurred through January 1, 2016 that may result in the assertion of additional claims. We currently carry professional and general liability insurance coverage (on a claims made basis) for this exposure with no deductible. We also carry D&O coverage (also on a claims made basis) for potential claims against our directors and officers, including securities actions, with deductibles ranging from $1 75 ,000 to $ 5 00,000 per claim.

We record estimated liabilities for our insurance programs based on information provided by the third-party plan administrators, historical claims experience, the life cycle of claims, expected costs of claims incurred but not paid, and expected costs to settle unpaid claims. We monitor our estimated insurance-related liabilities and recoveries, if any, on a monthly basis and as required by ASU 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries,* record amounts due under insurance policies in other current assets, while recording the estimated carrier liability in other current liabilities in the consolidated balance sheets. As facts change, it may become necessary to make adjustments that could be material to our results of operations and financial condition.

Goodwill and Other Intangible Assets

Intangible assets are stated at fair value at the time of acquisition and goodwill represents the excess cost over the fair value of net assets acquired and liabilities assumed. Finite lived intangible assets are amortized on a straight-line basis over the estimated useful life of the asset. Goodwill and indefinite-lived assets are not amortized. We perform impairment tests of goodwill and indefinite lived assets as required by ASC Topic 350, *Intangibles - Goodwill and Other* on at least an annual basis. An impairment analysis requires numerous subjective assumptions and estimates to determine fair value of the respective reporting units. We estimate the fair value of the related reporting units using a combined market approach (guideline company and similar transaction method) and income approach (discounted cash flow analysis). These models are based on our projections of future revenues and operating costs and are reconciled to our consolidated market capitalization. Discounted cash flow models are highly reliant on various assumptions. Significant assumptions we utilize in these models for the current year included: projected business results and future industry direction, long-term growth factor of 3% and weighted-average cost of capital of 15%. We use assumptions that we deem to be reasonable estimates of likely future events and compares the total fair values of each reporting unit to our overall market capitalization, and implied control premium, to determine if the fair values are reasonable compared to external market indicators. Subsequent changes in these key assumptions could affect the results of future goodwill impairment reviews.

Important to our overall impairment conclusion was the comparison of the aggregate fair values of the reporting units to our overall market capitalization at the annual assessment date, including the implied control premium, to determine if the fair values are reasonable compared to external market indicators. The aggregate fair value for each reporting unit did not exceed our market value as of the annual impairment testing date. A negative control premium indicates the high degree of conservatism built into our fair value models.

Because the fair value results for each reporting unit did not indicate a potential impairment existed, we did not recognize any goodwill impairment during the fiscal years ending January 1, 2016, December 31, 2014 and December 31, 2013 . Specifically, our VN and PC reporting unit fair value s w ere significantly over their carrying value . Based on the sensitivity analysis performed on two key assumptions in the discounted cash flow model s of each reporting unit, a 100 basis point change in either assumption (either individually or in the aggregate) would not result in any impairment of our goodwill within either reporting unit.

In calculating the fair value of VN within the model, we considered our cash flow projections and weighted average cost of capital to be conservative. Assuming no changes in the key assumptions identified and projected results, we currently anticipate the future fair value of both the VN and PC reporting units to increase over time; however, future declines in the operating results of either reporting unit could indicate a need to reevaluate the fair value of these businesses under U.S. GAAP requirements and may ultimately result in an impairment to goodwill. We will continue to monitor for any potential indicators of impairment.

Accounting for Income Taxes

We account for taxes in accordance with ASC Topic 740, *Income Taxes*. As of January 1, 2016, we have net deferred tax liabilities of approximately $13.1 million. The net deferred tax liability is composed of approximately $19.1 million of deferred tax assets and approximately $32.2 million of deferred tax liabilities. We have provided a valuation allowance against certain deferred tax assets based upon our estimates of realizability of those assets through future taxable income. This valuation allowance was based in large part on our history of generating operating income or losses in individual tax locales and expectations for the future. Our ability to generate the expected amounts of taxable income from future operations is dependent upon general economic conditions, competitive pressures on revenues and margins and legislation and regulation at all levels of government. Further, we have book goodwill of $ 113.2 million which is not deductible for tax purposes. The remaining deductible goodwill provides an annual tax deduction approximating $10.0 million through 2021. We have considered the above factors in reaching our conclusion that it is more likely than not that future taxable income will be sufficient to fully utilize the deferred tax assets (net of the valuation allowance) as of January 1, 2016.

RESULTS OF OPERATIONS

Year Ended January 1, 2016 Compared with Year Ended December 31, 2014
(In thousands)

Consolidated	January 1, 2016 (2) Amount	% Rev	December 31, 2014 Amount	% Rev	Change Amount	%
Home Health Operations						
Net service revenues:						
Visiting Nurse	$401,051	75.8 %	$380,788	77.2 %	$20,263	5.3 %
Personal Care	127,712	24.2 %	112,497	22.8 %	15,215	13.5 %
	528,763	100.0 %	493,285	100.0 %	35,478	7.2 %
Operating income before corporate expenses:						
Visiting Nurse	49,872	12.4 %	42,899	11.3 %	6,973	16.3 %
Personal Care	14,170	11.1 %	12,453	11.1 %	1,717	13.8 %
	64,042	12.1 %	55,352	11.2 %	8,690	15.7 %
Healthcare Innovations						
Revenue	3,451	100.0 %	2,544	100.0 %	907	35.7 %
Operating income before noncontrolling interest	(1,217)	-35.3%	(13)	-0.5%	(1,204)	NM
Corporate expenses	26,583	5.0 %	25,558	5.2 %	1,025	4.0 %
Deal, transition and other costs	4,139	0.8 %	5,304	1.1 %	(1,165)	-22.0%
Operating income	32,103	6.0 %	24,477	4.9 %	7,626	31.2 %
Interest expense, net	(2,006)	-0.4%	(1,442)	-0.3%	(564)	39.1 %
Income tax expense	(10,556)	-2.0%	(9,511)	-1.9%	(1,045)	11.0 %
Net income	$ 19,541	3.7 %	$ 13,524	2.7 %	$ 6,017	44.5 %
Adjusted EBITDA-HHO (1)	$ 43,938	8.3 %	$ 35,841	7.2 %	$ 8,097	22.6 %
Adjusted Earnings-HHO (1)	$ 21,411	4.0 %	$ 16,924	3.4 %	$ 4,487	26.5 %

(1) See page 48 for GAAP reconciliation of Adjusted EBITDA from home health operations and Adjusted earnings from home health operations.
(2) See page 35 for discussion regarding the Company's change to a 52-53 week reporting calendar in 2015.

Approximately $31. 2 million of our $35. 5 million year over year increase in Home Health revenue was a result of our acquisition of WillCare and Black Stone. Refer to VN and PC segment discussions for further operating performance details. Refer to "Fiscal Year End" related to our 52-53 week reporting conversion.

Healthcare Innovations ' operating loss was primarily due to the expected losses of our third quarter 2015 acquisition of Ingenios and to a lesser degree, higher losses in Imperium primarily related to a lower MSSP payments in 2015, as compared to 2014.

Corporate expenses as a percentage of revenue decreased slightly to 5.0% in 2015 from 5. 2 % in 2014. Deal, transition and other costs for 2015 include a net benefit of $4.2 million related to legal settlements, which was offset by $2.5 million of deal and transition costs related to our 2015 acquisitions, the $1.8 million provision for the Chapter 7 bankruptcy filing of a specific payor and $1.4 million related to the fourth quarter of 2015 closure of underperforming branch locations in the VN segment. Deal and transition costs in 2014 primarily related to the completion of the transition of our 2013 acquisitions.

Interest expense increased $0.6 million due to borrowings on our line of credit in conjunction with 2015 acquisitions.

Our effective tax rate for 2015 was 34.5% compared to 41.0% for 2014. The lower effective tax rate for 2015 was primarily r elated to the tax treatment of a legal settlement . Excluding the non-taxable settlement and other nondeductible deal costs, our effective tax rate for 2015 would have been 40.5%.

Visiting Nurse Segment-Years Ended January 1, 2016 and December 31, 2014

Approximately 94% of the VN segment revenues were generated from the Medicare program while the balance was generated from Medicaid and private insurance programs. In addition to our focus on operating income from the

Visiting Nurse segment, we also measure this segment's performance in terms of admissions, episodes, visits, patient months of care, revenue per episode and visits per episode. (In thousands, except statistical information)

	January 1, 2016 (2)		December 31, 2014		Change	
	Amount	% Rev	Amount	% Rev	Amount	%
Net service revenues	$ 401,051	100.0 %	$ 380,788	100.0 %	$ 20,263	5.3 %
Cost of service revenues	194,098	48.4 %	186,837	49.1 %	7,261	3.9 %
Gross margin	206,953	51.6 %	193,951	50.9 %	13,002	6.7 %
General and administrative expenses:						
Salaries and benefits	115,002	28.7 %	110,480	29.0 %	4,522	4.1 %
Other	42,079	10.5 %	40,572	10.7 %	1,507	3.7 %
Total general and administrative expenses	157,081	39.2 %	151,052	39.7 %	6,029	4.0 %
Operating income before corporate expenses	$ 49,872	12.4 %	$ 42,899	11.3 %	$ 6,973	16.3 %
Average number of locations	163		167		(4)	-2.4%
All payors:						
Patients Months	333,343		319,430		13,913	4.4 %
Admissions	102,381		98,634		3,747	3.8 %
Billable Visits	2,621,443		2,507,067		114,376	4.6 %
Medicare:						
Admissions (1)	91,027	88.9 %	87,650	88.9 %	3,377	3.9 %
Revenue (in thousands)	$ 377,724	94.2 %	$ 365,075	95.9 %	$ 12,649	3.5 %
Revenue per admission	$ 4,150		$ 4,165		$ (16)	-0.4%
Billable visits (1)	2,356,687	89.9 %	2,259,896	90.1 %	96,791	4.3 %
Recertifications	47,999		47,875		124	0.3 %
Payor mix % of Admissions						
Traditional Medicare Episodic	84.1 %		84.0 %		0.1 %	
Replacement Plans Paid Episodically	4.1 %		3.4 %		0.7 %	
Replacement Plans Paid Per Visit	11.8 %		12.6 %		(0.8)%	
Non-Medicare:						
Admissions (1)	11,354	11.1 %	10,984	11.1 %	370	3.4 %
Revenue (in thousands)	$ 23,327	5.8 %	$ 15,713	4.1 %	$ 7,614	48.5 %
Revenue per admission	$ 2,055		$ 1,431		$ 624	43.6 %
Billable visits (1)	264,756	10.1 %	247,171	9.9 %	17,585	7.1 %
Recertifications	2,991		1,865		1,126	60.4 %
Payor mix % of Admissions						
Medicaid & other governmental	30.6 %		23.3 %		7.3 %	
Private payors	69.4 %		76.7 %		(7.3)%	

(1) Percentages pertain to percentage of total admissions or total billable visits, as applicable.
(2) See page 35 for discussion regarding the Company's change to a 52-53 week reporting calendar in 2015.

VN segment net service revenues increased primarily due to the WillCare and Black Stone acquisitions which increased net service revenues by $15.3 million. The acquisitions increased operating income before corporate expenses by $ 3.0 million.

Substantially all of the changes in cost of service revenues and general and administrative expenses were due to the WillCare and Black Stone acquisitions.

Excluding the effects of the WillCare and Black Stone acquisitions, operating income before corporate expenses improved $ 3.9 million primarily due to higher volumes and an effective Medicare rate increase of about 1%.

Gross margin as a percent of revenue de creased 0. 7 % primarily due to organic volume growth, the Medicare rate increase and lower cost per visit. Total general and administrative expenses declined slightly as a percentage of revenue to 39.2 % from 39.7 % in the prior year primarily due to organic volume growth and the Medicare rate increase.

As a result, VN segment operating income before corporate expenses improved to $ 49.9 million from $42.9 million in the prior year, which VN segment operating income as a percentage of revenue increased to 12. 4 % from 11. 3 % in the prior year.

Personal Care Segment-Years Ended January 1, 2016 and December 31, 2014

Approximately 83% of the PC segment revenues were generated from Medicaid and other government programs while the balance is generated from insurance programs and private pay patients. (In thousands, except statistical information)

	January 1, 2016 (1)		December 31, 2014		Change	
	Amount	% Rev	Amount	% Rev	Amount	%
Net service revenues	$ 127,712	100.0 %	$ 112,497	100.0 %	$ 15,215	13.5 %
Cost of service revenues	86,642	67.8 %	76,865	68.3 %	9,777	12.7 %
Gross margin	41,070	32.2 %	35,632	31.7 %	5,438	15.3 %
General and administrative expenses:						
Salaries and benefits	17,373	13.6 %	14,523	12.9 %	2,850	19.6 %
Other	9,527	7.5 %	8,656	7.7 %	871	10.1 %
Total general and administrative expenses	26,900	21.1 %	23,179	20.6 %	3,721	16.1 %
Operating income before corporate expenses	$ 14,170	11.1 %	$ 12,453	11.1 %	$ 1,717	13.8 %
Average number of locations	65		61		4	6.6 %
Admissions	6,944		6,458		486	7.5 %
Patient months of care	110,082		89,880		20,202	22.5 %
Billable hours	5,792,106		5,304,089		488,017	9.2 %
Revenue per billable hour	$ 22.05		$ 21.21		$ 0.84	4.0 %

(1) See page 35 for discussion regarding the Company's change to a 52-53 week reporting calendar in 2015.

PC segment net revenue increased due to the WillCare and Black Stone acquisitions which increased net service revenues by $15. 9 million and operating income before corporate expenses by $2. 5 million.

Excluding the effects of the WillCare and Black Stone acquisitions, net service revenues decreased $ 0.7 million or 0.6 %, to $111. 8 million in 2015 from $112. 5 million in 2014 primarily due to a rate reduction for a specific program in Ohio. Cost of service revenues as a percentage of net service revenues de creased slightly to 67.8 % in 2015 from 68.3% in 2014.

Total general and administrative expenses in creased as a percent of net service revenues to 21.1 % from 20.6 % in 2014.

As a result, PC segment operating income before corporate expenses in creased to $1 4 . 2 million from $ 12.5 million in 2014, while operating income before corporate expenses as a percentage of revenue was unchanged.

Year Ended December 31, 2014 Compared with Year Ended December 31, 2013
(in thousands)

Consolidated	December 31, 2014 Amount	% Rev	December 31, 2013 Amount	% Rev	Change Amount	%
Home Health Operations						
Net service revenues:						
Visiting Nurse	$ 380,788	77.2 %	$ 263,789	73.9 %	$ 116,999	44.4 %
Personal Care	112,497	22.8 %	92,927	26.1 %	19,570	21.1 %
	493,285	100.0 %	356,716	100.0 %	136,569	38.3 %
Operating income before corporate expenses:						
Visiting Nurse	42,899	11.3 %	28,393	10.8 %	14,506	51.1 %
Personal Care	12,453	11.1 %	11,411	12.3 %	1,042	9.1 %
	55,352	11.2 %	39,804	11.2 %	15,548	39.1 %
Healthcare Innovations						
Revenue	2,544	100.0 %	196	100.0 %	2,348	1,198.0 %
Operating (loss) income before noncontrolling interest	(13)	-0.5%	(482)	-245.9%	469	NM %
Corporate expenses	25,558	5.2 %	20,206	5.7 %	5,352	26.5 %
Deal, transition and other costs	5,304	1.1 %	4,321	1.2 %	983	22.7 %
Operating income	24,477	4.9 %	14,795	4.1 %	9,682	65.4 %
Interest expense, net	(1,442)	-0.3%	(169)	0.0 %	(1,273)	753.3 %
Income tax expense	(9,511)	-1.9%	(6,020)	-1.7%	(3,491)	58.0 %
Net income from continuing operations	$ 13,524	2.7 %	$ 8,606	2.4 %	$ 4,918	57.1 %
Adjusted EBITDA-HHO(1)	$ 35,841	7.2 %	$ 23,637	6.6 %	$ 12,204	51.6 %
Adjusted Earnings-HHO(1)	$ 16,924	3.4 %	$ 11,532	3.2 %	$ 5,392	46.8 %

(1) See page 48 for GAAP reconciliation of Adjusted EBITDA from Home Health operations and Adjusted earnings from Home Health operations.

Approximately $127.6 million of our $136.6 million year over year increase in Home Health revenue was a result of our acquisition of SunCrest. The balance was generated from organic growth, partially offset by Medicare rate cuts in the VN segment. Refer to VN and PC segment discussions for further operating performance details.

Healthcare Innovations revenue increased $2.3 million year over year due to the receipt in 2014 of $1.6 million for Imperium's share of an MSSP payment, as a part of the first ever payments from CMS to ACOs under the ACA. Additionally, Imperium earns certain fees from ACOs that are not subject to earning an MSSP payment. Our Healthcare Innovations segment operations broke even in 2014, while losing $0.5 million in 2013.

Corporate expenses increased by $5. 4 million to $25. 6 million from $20.2 million in the prior year, while declining as a percentage of revenue to 5. 2 % from 5.7% last year. The 2014 period includes $4.4 million of incremental home office costs associated with the SunCrest acquisition. Additionally, 2014 included a $3.3 million provision for performance incentive programs while the prior year provision was zero.

During 2014, we consolidated several overlapping-territory Florida branches related to the SunCrest acquisition and closed SunCrest's Nashville based home office completing the last substantial steps of our integration plan. As a result, deal, transition and other include certain one-time lease and related abandonment charges. Deal, transition and other in 2014 also includes a $1.0 million benefit from insurance recoveries, net of costs incurred during 2014, related to legal defense costs incurred by the Company primarily in 2011 and 2010. The underlying cases were dismissed in 2014.

Interest expense increased $1.3 million due to borrowings on our line of credit in conjunction with the SunCrest acquisition.

Our effective tax rate in 2014 was 41.0% compared to 41.9% for 2013. The lower income tax rate in 2013 occurred primarily due to the Work Opportunity Tax Credit (WOTC) not being extended for 2012 until 2013 which resulted in our 2013 effective tax rate including the WOTC benefit for 2 years (2013 and 2012).

Visiting Nurse Segment-Years Ended December 31, 2014 and 2013

Approximately 96 % of the VN segment revenues were generated from the Medicare program while the balance was generated from Medicaid and private insurance programs. (In thousands, except statistical information)

	December 31, 2014		December 31, 2013		Change	
	Amount	% Rev	Amount	% Rev	Amount	%
Net service revenues	$ 380,788	100.0 %	$ 263,789	100.0 %	$ 116,999	44.4 %
Cost of service revenues	186,837	49.1 %	127,695	48.4 %	59,142	46.3 %
Gross margin	193,951	50.9 %	136,094	51.6 %	57,857	42.5 %
General and administrative expenses:						
Salaries and benefits	110,480	29.0 %	80,337	30.5 %	30,143	37.5 %
Other	40,572	10.7 %	27,364	10.4 %	13,208	48.3 %
Total general and administrative expenses	151,052	39.7 %	107,701	40.8 %	43,351	40.3 %
Operating income before corporate expenses	$ 42,899	11.3 %	$ 28,393	10.8 %	$ 14,506	51.1 %
Average number of locations	167		111		56	50.5 %
All payors:						
Patients Months	319,430		214,279		105,151	49.1 %
Admissions	98,634		64,304		34,330	53.4 %
Billable Visits	2,507,067		1,759,864		747,203	42.5 %
Medicare:						
Admissions (1)	87,650	88.9 %	58,441	90.9 %	29,209	50.0 %
Revenue (in thousands)	$ 365,075	95.9 %	$ 254,012	96.3 %	$ 111,063	43.7 %
Revenue per admission	$ 4,165		$ 4,346		$ (181)	-4.2%
Billable visits (1)	2,259,896	90.1 %	1,668,346	94.8 %	591,550	35.5 %
Recertifications	47,875		33,597		14,278	42.5 %
Payor mix % of Admissions						
Traditional Medicare Episodic	84.0 %		91.9 %		(7.9)%	
Replacement Plans Paid Episodically	3.4 %		2.6 %		0.8 %	
Replacement Plans Paid Per Visit	12.6 %		5.5 %		7.1 %	
Non-Medicare:						
Admissions (1)	10,984	11.1 %	5,863	9.1 %	5,121	87.3 %
Revenue (in thousands)	$ 15,713	4.1 %	$ 9,777	3.7 %	$ 5,936	60.7 %
Revenue per admission	$ 1,431		$ 1,668		$ (237)	-14.2%
Billable visits (1)	247,171	9.9 %	91,518	5.2 %	155,653	170.1 %
Recertifications	1,865		1,230		635	51.6 %
Payor mix % of Admissions						
Medicaid & other governmental	23.3 %		24.1 %		(0.8)%	
Private payors	76.7 %		75.9 %		0.8 %	

(1) Percentages pertain to percentage of total admissions or total billable visits, as applicable.

Visiting Nurse segment net service revenues increased primarily due to the SunCrest acquisition which increased net service revenues by $111.3 million. The SunCrest acquisition increased operating income before corporate expenses by $15.6 million.

Substantially all of the changes in cost of service revenues and general and administrative expenses were due to the SunCrest acquisition.

Excluding the effects of the SunCrest acquisition, operating income before corporate expenses improved $1.0 million as volume growth and cost improvements more than offset the impact of Medicare rate cuts which reduced revenue and operating income by $4.2 million. Medicare rate cuts were comprised of a 1.15% 2014 rate cut on episodes ending after December 31, 2013 and a 2.0% Medicare sequestration cut effective for episodes ended after March 2013.

Salaries and wages in 2014 included approximately $0.5 million of costs associated with employee pay increases in effect for the last five months of the year.

Personal Care Segment-Years Ended December 31, 2014 and 2013

Approximately 79% of the PC segment revenues were generated from Medicaid and other government programs while the balance is generated from insurance programs and private pay patients. (In thousands, except statistical information)

	December 31, 2014		December 31, 2013		Change	
	Amount	% Rev	Amount	% Rev	Amount	%
Net service revenues	$ 112,497	100.0 %	$ 92,927	100.0 %	$ 19,570	21.1 %
Cost of service revenues	76,865	68.3 %	62,621	67.4 %	14,244	22.7 %
Gross margin	35,632	31.7 %	30,306	32.6 %	5,326	17.6 %
General and administrative expenses:						
Salaries and benefits	14,523	12.9 %	12,349	13.3 %	2,174	17.6 %
Other	8,656	7.7 %	6,546	7.0 %	2,110	32.2 %
Total general and administrative expenses	23,179	20.6 %	18,895	20.3 %	4,284	22.7 %
Operating income before corporate expenses	$ 12,453	11.1 %	$ 11,411	12.3 %	$ 1,042	9.1 %
Average number of locations	61		61		—	0.0 %
Admissions	6,458		4,723		1,735	36.7 %
Patient months of care	89,880		80,045		9,835	12.3 %
Billable hours	5,304,089		4,682,590		621,499	13.3 %
Revenue per billable hour	$ 21.21		$ 19.85		$ 1.36	6.9 %

Net service revenues increased $19.6 million, or 21.1%, to $112.5 million in 2014 from $92.9 million in 2013, primarily due to the SunCrest acquisition which increased revenues by $16.2 million, with the remainder due to organic volume growth. Cost of service revenues as a percentage of net service revenues increased slightly to 68.3% in 2014 from 67.4% in 2013, primarily due to changes in business mix partially due to the SunCrest acquisition.

Total general and administrative expenses as a percent of net service revenues increased to 20.6% in 2014 from 20.3% in 2013.

As a result, PC segment operating income before corporate expenses increased to $12.5 million from $11.4 million in 2013, while operating income before corporate expenses as a percentage of revenue decreased 1.2 %.

Liquidity and Capital Resources

We believe that a certain amount of debt has an appropriate place in our overall capital structure, when reimbursement

visibility permits, and it is not our strategy to eliminate all debt financing. We believe that our cash flow from operations, cash on hand, and borrowing capacity on our bank credit facility, described below, will be sufficient to cover operating needs, future capital expenditure requirements and scheduled debt payments of miscellaneous small borrowing arrangements. In addition, it is likely that we will pursue growth from acquisitions, partnerships and other ventures that would be funded from excess cash from operations, cash on hand, credit available under the bank credit agreement and other financing arrangements that are normally available in the marketplace. Further, our board may pursue a stock repurchase program or may decide to pay special dividends in the future.

Revolving Credit Facility

We have a senior secured revolving credit facility with J.P. Morgan Securities LLC as Administrative Agent, Bank of America, N.A. as Syndication Agent, and certain other lenders (the "Facility"). The Facility consists of a $175 million credit line with a maturity date of November 15, 2020 and an "accordion" feature providing future expansion of the Facility to $250 million. Borrowings (other than letters of credit) under the credit facility generally will bear interest at a rate varying from London Interbank Offered Rate (LIBOR) rate plus 1.75% to LIBOR rate plus 3.00%, depending on leverage. The Facility is secured by substantially all of our assets and the stock of our subsidiaries. Debt issuance costs of $1.2 million are recorded in prepaid and other assets and is being amortized through November 15, 2020.

Borrowings under the Facility are subject to various covenants including a multiple of 3.5 times earnings before interest, taxes, depreciatio n and amortization ("EBITDA"). EBITDA may include "Acquired EBITDA" from pro-forma acquisitions as defined. Borrowings under the Facility may be used for general corporate purposes, including acquisitions. Application of the Facility's borrowing formula as of January 1, 2016 , would have permitted $ 43.4 million to be used. We had irrevocable letters of credit totaling $11.3 million outstanding in connection with our self-insurance programs, which resulted in a total of $ 32.1 million being available for use at January 1, 2016 . As of January 1, 2016 , we were in compliance with the various financial covenants. Under the most restrictive of its covenants, we were required to maintain minimum net worth of at least $177.5 million at January 1, 2016 . At such date, our net worth was approximately $270. 3 million.

The effective interest rates on our borrowings were 3.5 % and 2.7% for 2015 and 2014, respectively.

We believe the Facility will be sufficient to fund our operating needs and expansion plans for at least the next year. We will continue to evaluate additional capital, including possible debt and equity investments in the Company, to support a more rapid development of the business than would be possible with internal funds.

Cash Flows

Key elements to the Consolidated Statements of Cash Flows were as follows for the fiscal years: (in thousands):

Net Change in Cash and Cash Equivalents (in thousands)	2015	2014	2013
Provided by (used in):			
Operating activities	$ 21,206	$ 6,986	$ 19,546
Investing activities	(86,695)	(2,200)	(90,967)
Financing activities	66,125	(10,146)	55,209
Discontinued operations	—	—	2,338
Net increase (decrease) in cash and cash equivalents	$ 636	$ (5,360)	$ (13,874)

2015 Compared to 2014

Net cash provided by operating activities resulted primarily from current period net income of $19.5 million, plus certain non-cash items, net of changes in accounts receivable, accounts payable and accrued expenses. Accounts receivable days sales outstanding, which were 58 at January 1, 2016 and 55 at December 31, 2014, increas ing due to collection delays, primarily in the PC segment, as a result of changes in patient enrollment and billing requirements enacted by the Medicaid managed care providers in Tennessee.

The cash used in investing activities was primarily due to our 2015 acquisitions, capital expenditures of $3.1 million and a $1.0 million cost basis investment.

The cash provided by financing activities resulted from $67.3 million of new borrowings on the revolving credit facility and $1.2 million debt issuance costs incurred with the new five year $175 million credit facility.

2014 Compared to 2013

Net cash provided by operating activities resulted primarily from 2014 period net income of $13.5 million, plus certain non-cash items, which was partially offset by a net cash outflow related to the acquired SunCrest business. Conversion of SunCrest payroll, payment of other liabilities in excess of acquired cash and payment of SunCrest transition and severance related costs reduced cash flow from operating activities by $11.6 million. In addition, SunCrest clinical system conversions, transition of billing and collection activities from the SunCrest home office to our Louisville home office at the end of third quarter of 2014 and some non-SunCrest payer specific conversions to managed care combined to increase accounts receivable by $10.8 million. Conversely, tax benefits related to the SunCrest acquisition increased operating cash flow by $7.8 million. Cash from operating activities for 2014 was also reduced due to payment delays related to the conversion to managed care payers with longer payment cycles in certain same store PC segment markets.

The cash used in investing activities was primarily due to an April 2014 acquisition and capital expenditures.

The cash used in financing activities was primarily related to a $9.6 million payment on the line of credit drawn in connection with the 2013 SunCrest acquisition.

Acquisitions

The Company completed several acquisitions over the past three years and will continue to actively seek to acquire other quality providers of home health services like our current operations.

Factors which may affect future acquisition decisions include, but are not limited to, the quality and potential profitability of the business under consideration, potential regulatory limitations and our profitability and ability to finance the transaction. See Part II, Item 8, Notes 12 and 14 to the accompanying Notes to Consolidated Financial Statements for details regarding these acquisitions.

2016 Acquisitions
On January 5, 2016, we acquired 100% of the equity of Long Term Solutions, Inc. ("LTS"). LTS is a provider of in-home nursing assessments for the long-term care insurance industry. LTS provides assessments in all 50 U.S. states and a number of foreign countries. The purchase price of $37 million was funded through borrowings on the Company's bank credit facility, seller notes and issuance of the Company's common stock. LTS's post acquisition operating results will be reported in our Healthcare Innovations business segment.

On January 5, 2016, we purchased the assets of a Medicare-certified home health agency owned by Bayonne Visiting Nurse Association ('Bayonne") located in New Jersey. Bayonne's post acquisition operating results will be reported in our VN segment.
2015 Acquisitions

On November 5, 2015, we acquired the stock of Black Stone Operations, LLC ("Black Stone"). Black Stone is a provider of in-home personal care and skilled home health services in western Ohio and operates under the name "Home Care by Black Stone". The purchase price of $40 million was funded through borrowings on the Company's bank credit facility, seller notes and issuance of the Company's common stock. Black Stone's post acquisition operating results are primarily reported in our VN and PC segments.

On August 29, 2015, we acquired 100% of the equity of Bracor, Inc. (dba "WillCare"). WillCare, based in Buffalo, NY, reported $72 million in revenue for the year ended December 31, 2014 with VN and PC branch locations in New York (1 2) and Connecticut (1). The purchase price was approximately $50.8 million. The transaction was funded by

borrowings under the Company's bank credit facility. On March 1, 2015, we acquired the stock of WillCare's Ohio operations for $3.0 million.

On July 22, 2015, we acquired 100% of the equity of Ingenios Health Co. ("Ingenios") for approximately $11.4 million of the Company's common stock plus $2 million in cash. Ingenios is a leading provider of technology enabled in-home clinical assessments for Medicare Advantage, Managed Medicaid and Commercial Exchange lives in 7 states and Washington, D.C.

On January 29, 2015, we acquired a noncontrolling interest in a development stage analytics and software company, NavHealth, Inc. (NavHealth). The investment is an asset of our Health care Innovations segment.

2014 Acquisitions

During 2014, we completed a small acquisition using cash on hand to expand existing VN segment operations.

2013 Acquisitions

During 2013, in conjunction with our SunCrest and IHCN Acquisitions, we acquired 60 VN and 13 PC branch locations in Tennessee, Pennsylvania, Georgia, Indiana, Mississippi, Illinois, Florida and Alabama (in order of revenue significance). We funded these acquisitions with cash on hand of $31.8 million, $0.5 million in stock, issuance of a $1.5 million promissory note and borrowings of $56.0 million on our senior secured revolving credit facility.

In October of 2013, we also acquired a controlling interest in Imperium, a development-stage enterprise that provides strategic health management services to Accountable Care Organizations ("ACOs"). We acquired a 61.5% interest in Imperium for a total of $5.8 million of which $3 million went into Imperium for its general corporate purposes including pursuit of its business plan. The transaction was funded from cash on hand.

Contractual Obligations

The following table provides information about the payment dates of our contractual obligations at January 1, 2016 , excluding current liabilities except for the current portion of long-term debt and additional consideration related to acquisitions (in thousands):

	2016	2017	2018	2019	2020	Thereafter	Total
Revolving credit facility	$ —	$ —	$ —	$ —	$ 113,790	$ —	$ 113,790
Notes payable	—	—	5,000	1,500	—	—	6,500
Operating leases	8,439	5,930	3,698	2,153	1,634	2,793	24,647
Total	$ 8,439	$ 5,930	$ 8,698	$ 3,653	$ 115,424	$ 2,793	$ 144,937

Letters of Credit

We have outstanding letters of credit totaling $11.3 million at January 1, 2016 , which benefit our third-party insurer/administrators for our self-insurance programs. The amount of such insurance program letters of credit is subject to negotiation annually upon renewal and may vary in the future based upon such negotiation, our historical claims experience and expected future claims. It is reasonable to expect that the amount of the letter of credit will increase in the future, however, we are unable to predict to what degree.

We currently have no contingent obligations related to acquisition agreements.

Our commitments and contingencies are also impacted by our general and professional liabilities, pending litigation and investigations, and health care reform discussed elsewhere in this form 10-K. Please refer to Part I, Item 1, "Government Regulation", Part I, Item 1A, "Risk Factors", Part I, Item 3 "Legal Proceedings", Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations — Overview" and Part II, Item 8, "Notes to Consolidated Financial Statements".

Impact of Inflation

We do not believe that inflation has had a material effect on income during the past several years.

Non-GAAP Financial Measures

The information provided in this Annual Report use certain non-GAAP financial measures as defined under SEC rules. In accordance with SEC rules, the Company has provided, in the supplemental information and the footnotes to the tables, a reconciliation of those measures to the most directly comparable GAAP measures.

Adjusted Earnings from Home Health Operations

Adjusted earnings from home health operations ("Adjusted Earnings-HHO") is not a measure of financial performance under accounting principles generally accepted in the United States of America ("US GAAP"). It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. We believe the use of non-GAAP measures on a consolidated and business segment basis assists investors in understanding the ongoing operating performance by presenting comparable financial results between periods. The non-GAAP information provided is used by us and may not be determined in a manner consistent with the methodologies used by other companies.

	Fiscal Year ended		
(in thousands)	January 1, 2016	December 31, 2014	December 31, 2013
Net income attributable to Almost Family, Inc.	$ 20,009	$ 13,763	$ 8,226
Addbacks:			
Deal, transition and other, net of tax	737	3,156	2,572
Loss on discontinued operations, net of tax	—	—	558
Adjusted earnings	20,746	16,919	11,356
Healthcare Innovations operating (gain) loss after NCI, net of tax	665	5	176
Adjusted Earnings-HHO	$ 21,411	$ 16,924	$ 11,532
Per share amounts-basic:			
Average shares outstanding	9,505	9,333	9,279
Net income attributable to Almost Family, Inc.	$ 2.11	$ 1.47	$ 0.89
Addbacks:			
Deal, transition and other, net of tax	0.08	0.34	0.28
Loss on discontinued operations, net of tax	—	—	0.05
Adjusted earnings	2.18	1.81	1.22
Healthcare Innovations operating loss after NCI, net of tax	0.07	0.00	0.02
Adjusted Earnings-HHO	$ 2.25	$ 1.81	$ 1.24
Per share amounts-diluted:			
Average shares outstanding	9,745	9,462	9,374
Net income attributable to Almost Family, Inc.	$ 2.05	$ 1.45	$ 0.88
Addbacks:			
Deal, transition and other, net of tax	0.08	0.33	0.27
Loss on discontinued operations, net of tax	—	—	0.06
Adjusted earnings	2.13	1.79	1.21
Healthcare Innovations operating loss after NCI, net of tax	0.07	0.00	0.02
Adjusted Earnings-HHO	$ 2.20	$ 1.79	$ 1.23

(1) See page 35 for discussion regarding the Company's change to a 52-53 week reporting calendar in 2015.

Adjusted EBITDA from Home Health Operations

Adjusted earnings before interest, income tax, depreciation, amortization, amortization of stock-based compensation, Healthcare Innovations operating loss and deal, transition and other from Home Health Operations (Adjusted EBITDA-HHO) is not a measure of financial performance under U.S. GAAP. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from Adjusted EBITDA-HHO are significant components in understanding and evaluating financial performance and liquidity. Management routinely calculates and communicates Adjusted EBITDA-HHO and believes that it is useful to investors because it is commonly used as an analytical indicator within our industry to evaluate performance, measure leverage capacity and debt service ability, and to estimate current or prospective enterprise value. Adjusted EBITDA is used in certain covenants contained in our Credit Facility.

The following table sets forth a reconciliation of net income to Adjusted EBITDA-HHO for the fiscal year (in thousands):

	Fiscal Year ended		
(in thousands)	January 1, 2016 (1)	December 31, 2014	December 31, 2013
Net income attributable to Almost Family, Inc.	$ 20,009	$ 13,763	$ 8,226
Add back:			
Interest expense, net	2,006	1,442	167
Income tax expense	10,556	9,511	6,020
Depreciation and amortization	3,628	4,103	2,862
Stock-based compensation	2,121	1,814	1,465
Deal, transition and other costs	4,139	5,304	4,323
Adjusted EBITDA	42,459	35,937	23,063
Healthcare Innovations operating (gain) loss	1,479	(96)	574
Adjusted EBITDA-HHO	$ 43,938	$ 35,841	$ 23,637

(1) See page 35 for discussion regarding the Company's changed to a 52-53 week reporting calendar in 2015.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Ris k

Derivative Instruments

We do not use derivative instruments.

Market Risk of Financial Instruments

Our primary market risk exposure with regard to financial instruments is to changes in interest rates.

At January 1, 2016 , a hypothetical 100 basis point increase in short-term interest rates would result in a reduction of approximately $ 1.2 million in our annual pre-tax earnings.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DAT A

ALMOST FAMILY, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOM E
(In thousands, except per share data)

	Fiscal Year ended		
	January 1, 2016	December 31, 2014	December 31, 2013
Net service revenues	$ 532,214	$ 495,829	$ 356,912
Cost of service revenues (excluding depreciation and amortization)	281,842	263,994	190,548
Gross margin	250,372	231,835	166,364
General and administrative expenses:			
Salaries and benefits	147,849	139,793	102,005
Other	66,281	62,261	45,243
Deal, transition and other non-recurring costs	4,139	5,304	4,323
Total general and administrative expenses	218,269	207,358	151,571
Operating income	32,103	24,477	14,793
Interest expense, net	(2,006)	(1,442)	(167)
Income before income taxes	30,097	23,035	14,626
Income tax expense	(10,556)	(9,511)	(6,020)
Net income from continuing operations	19,541	13,524	8,606
Discontinued operations:			
(Loss) gain from operations, net of tax of $882	—	—	(729)
Gain on sale, net of tax of $973	—	—	171
(Loss) gain on discontinued operations	—	—	(558)
Net income	19,541	13,524	8,048
Net (income) loss attributable to noncontrolling interest	468	239	178
Net income attributable to Almost Family, Inc.	$ 20,009	$ 13,763	$ 8,226
Per share amounts-basic:			
Average shares outstanding	9,505	9,333	9,279
Income from continued operations attributable to Almost Family, Inc.	$ 2.11	$ 1.47	$ 0.95
Discontinued operations	—	—	(0.06)
Net income attributable to Almost Family, Inc.	$ 2.11	$ 1.47	$ 0.89
Per share amounts-diluted:			
Average shares outstanding	9,745	9,462	9,374
Income from continued operations attributable to Almost Family, Inc.	$ 2.05	$ 1.45	$ 0.94
Discontinued operations	—	—	(0.06)
Net income attributable to Almost Family, Inc.	$ 2.05	$ 1.45	$ 0.88

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

***ALMOST FAMILY, INC.* AND SUBSIDIARIES**
CONSOLIDATED BALANCE SHEET S
(In thousands)

	January 1, 2016	December 31, 2014
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 7,522	$ 6,886
Accounts receivable - net	92,270	74,602
Prepaid expenses and other current assets	9,672	10,420
TOTAL CURRENT ASSETS	109,464	91,908
PROPERTY AND EQUIPMENT - NET	10,000	5,575
GOODWILL	277,061	192,523
OTHER INTANGIBLE ASSETS	64,629	54,402
OTHER ASSETS	3,615	850
TOTAL ASSETS	$ 464,769	$ 345,258
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Accounts payable	$ 12,297	$ 9,257
Accrued other liabilities	42,524	42,326
Current portion - notes payable and capital leases	—	51
TOTAL CURRENT LIABILITIES	54,821	51,634
LONG-TERM LIABILITIES:		
Revolving credit facility	113,790	46,447
Deferred tax liabilities	13,094	11,280
Seller notes	6,556	1,500
Other liabilities	2,608	1,205
TOTAL LONG-TERM LIABILITIES	136,048	60,432
TOTAL LIABILITIES	190,869	112,066
NONCONTROLLING INTEREST - REDEEMABLE - HEALTHCARE INNOVATIONS	3,639	3,639
STOCKHOLDERS' EQUITY:		
Preferred stock, par value $0.05; authorized 2,000 shares; none issued or outstanding	—	—
Common stock, par value $0.10; authorized 25,000; 10,125 and 9,574 issued and outstanding	1,013	957
Treasury stock, at cost, 103 and 94 shares	(2,731)	(2,392)
Additional paid-in capital	127,253	105,862
Noncontrolling interest - nonredeemable	(730)	(420)
Retained earnings	145,456	125,546
TOTAL STOCKHOLDERS' EQUITY	270,261	229,553
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 464,769	$ 345,258

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

ALMOST FAMILY, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands)

	Common Stock Shares	Common Stock Amount	Treasury Stock Shares	Treasury Stock Amount	Additional Paid-in Capital	Retained Earnings	Non-controlling Interest - Non-redeemable	Total Stockholders' Equity	Non-controlling Interest - Redeemable
Balance, December 31, 2012	9,421	$ 942	(91)	$ (2,320)	$ 101,945	$ 103,748	$ —	$ 204,315	$ —
Stock award maturities, net of shares surrendered or withheld	1	1	(1)	(20)	17	—	—	(2)	—
Share awards and related compensation	52	5	—	—	1,460	—	—	1,465	—
Tax loss from stock-based compensation	—	—	—	—	(62)	—	—	(62)	—
Stock provided in acquisitions	26	2	—	—	498	—	—	500	—
Acquired noncontrolling interest	—	—	—	—	0	—	(193)	(193)	3,639
Net loss noncontrolling interests - redeemable	—	—	—	—	—	—	—	—	(185)
Noncontrolling interests - redeemable fair value accretion	—	—	—	—	—	(185)	—	(185)	185
Net loss noncontrolling interests - nonredeemable	—	—	—	—	—	—	7	7	—
Net income attributable to Almost Family, Inc.	—	—	—	—	—	8,226	—	8,226	—
Balance, December 31, 2013	9,500	$ 950	(92)	$ (2,340)	$ 103,858	$ 111,789	$ (186)	$ 214,071	$ 3,639
Stock award maturities, net of shares surrendered or withheld	14	1	(2)	(52)	156	—	—	105	—
Share awards and related compensation	60	6	—	—	1,808	—	—	1,814	—
Tax gain from stock-based compensation	—	—	—	—	40	—	—	40	—
Net loss noncontrolling interests - redeemable	—	—	—	—	—	—	—	—	(6)
Noncontrolling interests - redeemable fair value accretion	—	—	—	—	—	(6)	—	(6)	6
Net loss noncontrolling interests - nonredeemable	—	—	—	—	—	—	(234)	(234)	—
Net income attributable to Almost Family, Inc.	—	—	—	—	—	13,763	—	13,763	—
Balance, December 31, 2014	9,574	$ 957	(94)	$ (2,392)	$ 105,862	$ 125,546	$ (420)	$ 229,553	$ 3,639
Stock award maturities, net of shares surrendered or withheld	10	1	(9)	(339)	128	—	—	(210)	—
Share awards and related compensation	100	11	—	—	2,110	—	—	2,121	—
Tax gain from stock-based compensation	—	—	—	—	215	—	—	215	—
Stock provided in acquisitions	441	44	—	—	18,938	—	—	18,982	(99)
Net loss noncontrolling interests - redeemable	—	—	—	—	—	—	—	—	99
Noncontrolling interests - redeemable fair value accretion	—	—	—	—	—	(99)	—	(99)	—
Net loss noncontrolling interests - nonredeemable	—	—	—	—	—	—	(310)	(310)	—
Net income attributable to Almost Family, Inc.	—	—	—	—	—	20,009	—	20,009	—
Balance, January 1, 2016	10,125	$ 1,013	(103)	$ (2,731)	$ 127,253	$ 145,456	$ (730)	$ 270,261	$ 3,639

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

ALMOST FAMILY, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOW S
(in thousands)

	Fiscal Year ended		
	January 1, 2016	December 31, 2014	December 31, 2013
Cash flows from operating activities:			
Net income	$ 19,541	$ 13,524	$ 8,048
Loss on discontinued operations, net of tax	—	—	(558)
Net income from continuing operations	19,541	13,524	8,606
Adjustments to reconcile income to net cash provided by operating activities:			
Depreciation and amortization	4,208	4,103	2,862
Provision for uncollectible accounts	12,743	9,417	5,378
Stock-based compensation	2,121	1,814	1,465
Deferred income taxes	3,914	5,500	2,099
	42,527	34,358	20,410
Change in certain net assets and liabilities, net of the effects of acquisitions:			
(Increase) decrease in:			
Accounts receivable	(17,393)	(25,613)	(4,440)
Prepaid expenses and other current assets	2,402	(647)	4,229
Other assets	(585)	165	235
Accounts payable and accrued expenses	(5,745)	(1,277)	(888)
Net cash provided by operating activities	21,206	6,986	19,546
Cash flows from investing activities:			
Capital expenditures	(3,117)	(1,231)	(2,502)
Cost basis investment	(1,000)	—	—
Acquisitions, net of cash acquired	(82,578)	(969)	(88,465)
Net cash used in investing activities	(86,695)	(2,200)	(90,967)
Cash flows from financing activities:			
Credit facility borrowings	233,425	66,632	56,000
Credit facility repayments	(166,082)	(76,185)	—
Debt issuance fees	(1,161)	—	—
Proceeds from stock option exercises	128	156	11
Purchase of common stock in connection with share awards	(338)	(52)	(20)
Tax impact of share awards	215	40	(62)
Payment of special dividend	(50)	(35)	—
Principal payments on notes payable and capital leases	(12)	(702)	(720)
Net cash provided by (used in) financing activities	66,125	(10,146)	55,209
Cash flows from discontinued operations:			
Operating activities	—	—	(742)
Investing activities	—	—	3,080
Net cash from discontinued operations	—	—	2,338
Net change in cash and cash equivalents	636	(5,360)	(13,874)
Cash and cash equivalents at beginning of period	6,886	12,246	26,120
Cash and cash equivalents at end of period	$ 7,522	$ 6,886	$ 12,246
Supplemental disclosures of cash flow information:			
Cash payment of interest, net of amounts capitalized	$ 1,890	$ 1,264	$ 97
Cash payment of taxes	$ 4,651	$ 1,953	$ 6,084
Summary of non-cash investing and financing activities:			
Acquisitions funded by notes payable	$ 5,000	$ —	$ 1,500
Acquisitions funded by stock	$ 18,982	$ —	$ 500

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

ALMOST FAMILY, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENT S
(Unless otherwise indicated all dollar and share amounts are in thousands)

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Consolidation and Description Of Business

The consolidated financial statements include the accounts of *Almost Family, Inc.* (a Delaware corporation) and its wholly-owned subsidiaries (collectively " *Almost Family* " or the "Company"). The Company is a leading, regionally focused provider of home health services and has service locations in Florida, Ohio, Tennessee, New York, Kentucky, Connecticut, New Jersey, Massachusetts, Indiana, Illinois, Pennsylvania, Georgia, Missouri, Mississippi and Alabama (in order of revenue significance).

The Company was incorporated in Delaware in 1985. Through a predecessor that merged into the Company in 1991, the Company has been providing health care services, primarily home health care, since 1976. All material intercompany transactions and accounts have been eliminated in consolidation.

On November 5, 2015, the Company completed the acquisition of Black Stone Operations, LLC ("Black Stone"). Black Stone owned and operated personal care and skilled home health services in western Ohio. On August 29, 2015, the Company completed the acquisition of Bracor, Inc. (dba WillCare). WillCare owned and operated Visiting Nurse ("VN") and Personal Care ("PC") branch locations in New York (1 2), and Connecticut (1). On July 22, 2015, the Company acquired Ingenios Health ("Ingenios"). Ingenios is a leading provider of technology enabled in-house clinical assessments for Medicare Advantage, Managed Medicaid and Commercial Exchange lives in seven states and Washington, D.C. On March 2, 2015, the Company acquired the stock of Willcare's Ohio operations. On January 29, 2015, the Company acquired a noncontrolling interest in a development stage analytics and software company, NavHealth, Inc. ("NavHealth"). The results of operations for WillCare and Black Stone are reported in the Company's VN and PC segments, while Ingenios results are included in the Company's Healthcare Innovations segment.

On December 6, 2013, the Company completed the acquisition of Omni Home Health Holdings, Inc. ("SunCrest"). Branded principally under the SunCrest name, its subsidiaries owned and operated 66 Medicare-certified home health agencies and 9 private duty agencies in Florida, Tennessee, Georgia, Pennsylvania, Kentucky, Illinois, Indiana, Mississippi and Alabama. On October 4, 2013, the Company acquired a controlling interest in Imperium Health Management, LLC ("Imperium"), a development-stage enterprise that provides strategic health management services to Accountable Care Organizations ("ACOs"). On July 17, 2013, the Company acquired the assets of the Medicare-certified home health agencies owned by Indiana Home Care Network ("IHCN"). The acquisitions are more fully described in Note 12, "Acquisitions". The results of operations for SunCrest and IHCN are principally reported within the Company's VN reportable segment, while Imperium results are included in the Company's Healthcare Innovations segment. The Company's consolidated financial statements are prepared in accordance with U.S. generally accepted accounting principles (US GAAP). All intercompany balances and transactions have been eliminated.

Fiscal Year End

Effective with the first quarter of 2015, the Company adopted a 52-53 week fiscal reporting calendar under which it will report its annual results going forward in four equal 13-week quarters. Every fifth year, one quarter will include 14 weeks and that year will include 53 weeks of operating results.

New Accounting Pronouncements

The Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-09, Revenue from Contracts with Customers (Topic 606), during the second quarter of 2014. Topic 606 affects virtually all aspects of an entity's revenue recognition, including determining the measurement of revenue and the timing of when it

is recognized for the transfer of goods or services to customers. Topic 606 is effective for annual reporting periods beginning after December 15, 2017. The Company is currently evaluating the effect of the adoption of Topic 606 on its financial position and results of operations.

In April 2014, the FASB issued ASU No. 2014-18, Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity, which includes amendments of Accounting Standards Codification (ASC 205 Presentation of Financial Statements and ASC 360 Property, Plant and Equipment) which limits the requirement for discontinued operations treatment to the disposal of a component of an entity, or a group of components of an entity, that represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. Additionally, this new guidance no longer precludes discontinued operations presentation based on continuing involvement or cash flows following the disposal. This guidance became effective prospectively for the Company on January 1, 2015, and will impact the Company's determination and disclosure of discontinued operations treatment for subsequent qualifying divestitures, if any.

In April 2015, the FASB issued ASU No. 2015-03, Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs. In certain cases, Subtopic 835-30 requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability. Subtopic 835-30 is effective for annual and interim periods beginning after December 15, 2015. The Company does not expect ASU No. 2015-03 to materially affect its financial position and results of operation.

In April 2015, the FASB issued ASU No. 2015-05, Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Fees Paid in a Cloud Computing Arrangement . Subtopic 350-40 provides guidance that all software licenses included in cloud computing arrangement be accounted for consistent with other licenses of intangible assets. However if a cloud computing arrangement does not include a software license, the arrangement should be accounted for as a service contract, the accounting for which did not change. Subtopic 350-40 is effective for annual and interim periods beginning after December 15, 2015. The Company does not expect ASU No. 2015-05 to materially affect its financial position and results of operations.

In November 2015, the FASB issued ASU no. 2015-17, Balance Sheet Classification of Deferred Taxes. The new guidance requires that all deferred tax assets and liabilities, along with any related valuation allowance, be classified as noncurrent on the balance sheet. As a result, each jurisdiction will now only have one net noncurrent deferred tax asset or liability. The Company elected to early adopt this guidance with retrospective treatment which required reclassification of the consolidated balance sheet. Accordingly, $12.2 million was reclassified in the prior year presentation to confirm with the current year presentation.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents.

Uninsured deposits at January 1, 2016 and December 31, 2014 were approximately $4,681 and $4,183 respectively. These amounts have been deposited with national financial institutions.

Property and Equipment

Property and equipment are stated at cost. Depreciation is computed using the straight-line method over the estimated useful lives (generally two to ten years for medical and office equipment and three years for internally developed software). Leasehold improvements are depreciated over the terms of the respective leases (generally three to ten years). Such costs are periodically reviewed for recoverability when impairment indicators are present. Such indicators include, among other factors, operating losses, unused capacity, market value declines and technological obsolescence. Recorded values of asset groups of property, plant and equipment that are not expected to be recovered through undiscounted future net cash flows are written down to current fair value, which generally is determined from estimated discounted future net cash flows (assets held for use) or net realizable value (assets held for sale).

Goodwill and Other Intangible Assets

Goodwill and indefinite lived intangible assets acquired are stated at fair value at the date of acquisition. Subsequent to acquisition, the Company conducts annual reviews for impairment, or more frequently if circumstances indicate impairment may have occurred. The Company reviews goodwill for impairment based on its identified reporting units, which are the same as its reportable segments. The Company tests goodwill for impairment by comparing the carrying value to the estimated fair value of its reporting units, determined using a combination of the market approach (guideline company *and* similar transaction method) and income approach (discounted cash flow analysis). The Company annually tests its indefinite-lived intangible assets, principally trade names, certificates of need, provider numbers and licenses. Specifically trade names are tested using a "relief-from-royalty" valuation method compared to the carrying value. Significant assumptions inherent in the valuation methodologies for goodwill and other intangibles are employed and include, but are not limited to, such estimates as future projected business results, growth rates, legislated changes in payment rates, weighted-average cost of capital for a market participant, royalty and discount rates . The Company has completed its most recent annual impairment tests as of January 1, 2016 and determined that no impairment existed.

Finite-lived intangible assets are amortized on a straight-line basis over their estimated useful lives, such as the cost of non-compete agreements for which their estimated useful life is usually 3 years, beginning after the earn-out period, if any.

The following table summarizes the activity related to the Company's goodwill and other intangible assets:

		Other Intangible Assets			
	Goodwill	Certificates of Need and Licenses	Trade Names	Non-compete Agreements	Total
Balances at December 31, 2013	$192,489	$ 38,321	$14,781	$ 72	$53,174
Acquisitions	—	1,290	—	—	1,290
Changes	34	—	—	—	—
Amortization	—	—	(10)	(52)	(62)
Balances at December 31, 2014	$192,523	$ 39,611	$14,771	$ 20	$54,402
Acquisitions	84,538	6,433	3,640	180	10,253
Amortization	—	—	(10)	(16)	(26)
Balances at January 1, 2016	$277,061	$ 46,044	$18,401	$ 184	$64,629

See Note 12 for further discussion of acquisitions .

The following table summarizes the Company's goodwill and other intangible assets by segment:

		Other Intangible Assets			
	Goodwill	Certificates of Need and Licenses	Trade Names	Non-compete Agreements	Total
Visiting Nurse	$147,368	$ 38,831	$11,391	$ 10	$50,232
Personal Care	37,571	780	3,380	10	4,170
Healthcare Innovations	7,584	—	—	—	—
December 31, 2014 balance	$192,523	$ 39,611	$14,771	$ 20	$54,402
Visiting Nurse	$186,384	$ 42,884	$13,206	$ 92	$56,182
Personal Care	72,773	3,160	5,195	92	8,447
Healthcare Innovations	17,904	—	—	—	—
January 1, 2016 balance	$277,061	$ 46,044	$18,401	$ 184	$64,629

Capitalization Policies

Maintenance, repairs and minor replacements are charged to expense as incurred. Major renovations and replacements are capitalized to appropriate property and equipment accounts. Upon sale or retirement of property, the cost and related accumulated depreciation are eliminated from the accounts and the related gain or loss is recognized in the consolidated statement of income.

The Company capitalizes the cost of internally developed computer software for the Company's own use. Software development costs of approximately $788 , $327 and $647 were capitalized in the years ended January 1, 2016 , December 31, 2014 and 2013, respectively.

Insurance Programs

The Company bears significant risk under its large-deductible workers' compensation insurance program and its self-insured employee health program. Under the workers' compensation insurance program, the Company bears risk up to $400 per incident, except for a recent acquisition that has not yet been folded into the Company's program and has a stop-loss of $750, after which stop-loss coverage is maintained. The Company purchases stop-loss insurance for the employee health plan that places a specific limit, generally $300, on its exposure for any individual covered life.

Malpractice and general patient liability claims for incidents which may give rise to litigation have been asserted against the Company by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. The Company currently carries professional and general liability insurance coverage (on a claims made basis) for this exposure with no deductible. The Company also carries D&O coverage (also on a claims made basis) for potential claims against the Company's directors and officers, including securities actions, with deductibles ranging from $1 75 to $5 00 per claim.

The Company records estimated liabilities for its insurance programs based on information provided by the third-party plan administrators, historical claims experience, the life cycle of claims, expected costs of claims incurred but not paid, and expected costs to settle unpaid claims. The Company monitors its estimated insurance-related liabilities and recoveries, if any, on a monthly basis and records amounts due under insurance policies in other current assets, while recording the estimated carrier liability in other current liabilities. As facts change, it may become necessary to make adjustments that could be material to the Company's results of operations and financial condition.

Accounting for Income Taxes

The Company recognizes deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the financial statements or tax returns. Under this method, deferred tax assets and liabilities are determined based on the difference between the Company's book and tax bases of assets and liabilities and tax carry-forwards using enacted tax rates in effect for the year in which the differences are expected to reverse. The effect of changes in tax rates on deferred taxes is recognized in the period in which the enactment dates change. Valuation allowances are established when necessary on a jurisdictional basis to reduce deferred tax assets to the amounts expected to be realized.

Seasonality

The Company's VN segment operations located in Florida (which generated approximately 2 4 % of that segment's revenues in the year ended January 1, 2016) normally experience higher admissions during the first quarter and lower admissions during the third quarter than in the other quarters due to seasonal population fluctuations.

Net Service Revenues

The Company is paid for its services primarily by federal and state third-party reimbursement programs, commercial insurance companies, and patients. Revenues are recorded at established rates in the period during which the services are

rendered. Appropriate allowances to give recognition to third party payment arrangements are recorded when the services are rendered.

Approximately 71% of the Company's consolidated net service revenues are derived from the Medicare program. Net service revenues are recorded under the Medicare prospective payment program (PPS) based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) changes in the base episode payments established by the Medicare program; (b) adjustments to the base episode payments for case-mix and geographic wages; (c) a low utilization payment adjustment (LUPA) if the number of visits was fewer than five; (d) a partial payment if a patient is transferred to another provider or if a patient is received from another provider before completing the episode; (e) a payment adjustment based upon the level of therapy services required (thresholds set at 6, 14 and 20 visits); (f) an outlier payment if the patient's care was unusually costly (capped at 10% of total reimbursement); (g) the number of episodes of care provided to a patient; and (h) a 2% reduction for sequestration.

At the beginning of each Medicare episode the Company calculates an estimate of the amount of expected reimbursement based on the variables outlined above and recognizes Medicare revenue on an episode-by-episode basis during the course of each episode over its expected number of visits. Over the course of each episode, as changes in the variables become known, adjustments are calculated and recorded as needed to reflect changes in expectations for that episode from those established at the start of the 60 day period until its ultimate outcome at the end of the 60 day period is known.

Substantially all remaining revenues are earned on a per visit, hour or unit basis (as opposed to episodic). For all services provided, the Company uses either payor-specific or patient-specific fee schedules for the recording of revenues at the amounts actually expected to be received.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. It is common for issues to arise related to: 1) medical coding, particularly with respect to Medicare, 2) patient eligibility, particularly related to Medicaid, and 3) other reasons unrelated to credit risk, all of which may result in adjustments to recorded revenue amounts. The Company continuously evaluates the potential for revenue adjustments and when appropriate provides allowances for losses based upon the best available information. There is at least a reasonable possibility that recorded estimates could change by material amounts in the near term. Changes in estimates related to prior periods (increased) decreased revenues by approximately ($365), ($320), and $114 in the years ended January 1, 2016 , December 31, 2014 and 2013, respectively.

Revenue and Receivable Concentrations

The following table sets forth the percent of the Company's revenues generated from Medicare, state Medicaid programs and other payors for the fiscal year ended:

	January 1, 2016	December 31, 2014	December 31, 2013
Medicare	71.4 %	72.4 %	71.2 %
Medicaid & other government programs:			
Ohio	9.1 %	8.8 %	11.7 %
Connecticut	5.5 %	5.5 %	7.1 %
Tennessee	3.2 %	2.5 %	0.2 %
Kentucky	1.7 %	1.8 %	2.3 %
New York	1.7 %	— %	— %
Florida	0.9 %	0.6 %	0.7 %
Others	0.4 %	0.4 %	0.5 %
Subtotal	22.5 %	19.6 %	22.5 %
All other payors	6.1 %	8.0 %	6.3 %
Total	100.0 %	100.0 %	100.0 %

Concentrations in the Company's accounts receivable were as follows:

	January 1, 2016		December 31, 2014	
	Amount	Percent	Amount	Percent
Medicare	$ 50,369	45.9 %	$46,342	55.5 %
Medicaid & other government programs:				
Ohio	8,627	7.9 %	9,239	11.1 %
Tennessee	8,038	7.3 %	5,617	6.7 %
New York	3,207	2.9 %	—	— %
Kentucky	3,055	2.8 %	3,686	4.4 %
Florida	2,702	2.5 %	1,804	2.2 %
Connecticut	2,693	2.5 %	3,982	4.8 %
Others	1,156	1.1 %	1,031	1.2 %
Subtotal	29,478	26.9 %	25,359	30.4 %
All other payors	29,937	27.3 %	11,781	14.1 %
Subtotal	109,784	100.0 %	83,482	100.0 %
Allowances	(17,514)		(8,880)	
Total	$ 92,270		$74,602	

The ability of payors to meet their obligations depends upon their financial stability, future legislation and regulatory actions. The Company does not believe there are any significant credit risks associated with receivables from Federal and state third-party reimbursement programs. The allowance for uncollectible accounts principally consists of management's estimate of amounts that may prove uncollectible for coverage, eligibility and technical reasons.

Payor Mix Concentrations and Related Aging of Accounts Receivable

The approximate breakdown by payor classification as a percent of total accounts receivable, net of contractual allowances, if any, were as follows:

	January 1, 2016				
Payor	0-90	91-180	181-365	>1 yr.	Total
Medicare	26 %	10 %	7 %	3 %	46 %
Medicaid & Government	12 %	4 %	8 %	3 %	27 %
Self Pay	6 %	1 %	1 %	1 %	9 %
Insurance	7 %	2 %	5 %	4 %	18 %
Total	51 %	17 %	21 %	11 %	100 %

	December 31, 2014				
Payor	0-90	91-180	181-365	>1 yr.	Total
Medicare	36 %	13 %	7 %	0 %	56 %
Medicaid & Government	19 %	6 %	4 %	1 %	30 %
Self Pay	1 %	0 %	2 %	0 %	3 %
Insurance	6 %	3 %	2 %	0 %	11 %
Total	62 %	22 %	15 %	1 %	100 %

Variations between years are largely attributable to the WillCare and Black Stone acquisitions.

Allowance for Uncollectible Accounts by Payor Mix and Related Aging

The Company records an estimated allowance for uncollectible accounts by applying estimated bad debt percentages to its accounts receivable aging. The percentages to be applied by payor type are based on the Company's historical collection and loss experience. The Company's effective allowances for uncollectible accounts as a percent of accounts receivable were as follows:

	January 1, 2016				
Payor	0-90	91-180	181-365	>1 yr.	>2 yrs.
Medicare	3 %	6 %	36 %	55 %	100 %
Medicaid & Government	4 %	5 %	44 %	46 %	100 %
Self Pay	4 %	3 %	34 %	59 %	100 %
Insurance	3 %	5 %	36 %	56 %	100 %
Total	3 %	5 %	38 %	53 %	100 %

	December 31, 2014				
Payor	0-90	91-180	181-365	>1 yr.	>2 yrs.
Medicare	0 %	0 %	8 %	75 %	100 %
Medicaid & Government	1 %	8 %	31 %	66 %	100 %
Self Pay	1 %	12 %	51 %	74 %	100 %
Insurance	5 %	22 %	46 %	83 %	100 %
Total	1 %	6 %	23 %	74 %	100 %

Variations between years are largely attributable to the WillCare and Black Stone acquisitions.

The Company's allowance for uncollectible accounts at January 1, 2016 and December 31, 2014 was approximately $17,514 and $8,880, respectively. The increase is primarily due to the timing of write-offs and to a lesser degree, the 2015 acquisitions.

Contingent Service Revenues

The Company, through its Imperium acquisition, provides strategic health management services to ACOs that have been approved to participate in the Medicare Shared Savings Program ("MSSP"). In some cases, the Company also had ownership interests in ACOs beginning January 1, 2015.

ACOs are entities that contract with CMS to serve the Medicare fee-for-service population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. The MSSP is relatively new and therefore has limited historical experience, which impacts the Company's ability to accurately accumulate and interpret the data available for calculating an ACOs' shared savings, if any. MSSP payments are not recognized in revenue until persuasive evidence of an agreement exists, services have been rendered, the payment is fixed and determinable and collectability is insured, which is generally satisfied upon cash receipt. Under such agreements, the Company recognized $1.4 million and $1.6 million in MSSP payments for cash received during 2015 and 2014, respectively, related to savings generated for the program period ended December 31, 2013 and Decem ber 31, 2014, respectively , which is included in the Company's Healthcare Innovations segment revenues. The Company has yet to recognize MSSP payments, if any, for savings generated through January 1, 2016

Weighted Average Shares

Net income per share is presented as a unit of basic shares outstanding and diluted shares outstanding. Diluted shares outstanding is computed based on the weighted average number of common shares and common equivalent shares outstanding. Common equivalent shares result from dilutive stock options and unvested restricted shares. The following table is a reconciliation of basic to diluted shares used in the earnings per share calculation for the fiscal year ended:

	January 1, 2016	December 31, 2014	December 31, 2013
Basic weighted average outstanding shares	9,505	9,333	9,279
Dilutive effect of outstanding compensation awards	240	129	95
Diluted weighted average outstanding shares	9,745	9,462	9,374

The assumed conversions to common stock of 20, 94, and 195 of the Company's outstanding stock options were excluded from the diluted EPS computation in 2015, 2014, and 2013, respectively, because these items, on an individual basis, have an anti-dilutive effect on diluted EPS.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Financial Statement Reclassifications

Certain prior period amounts and data have been reclassified in the financial statements and related notes in order to conform to the 2015 presentation.

Stock-Based Compensation

Stock options and restricted stock are granted under various stock compensation programs to employees and independent directors. The Company accounts for such grants in accordance with ASC Topic 718, *Compensation — Stock Compensation* and amortizes the fair value of awards, after estimated forfeiture, on a straight-line basis over the requisite service periods.

Accounting for Leases

The Company accounts for operating leases using the straight-line rents method, which amortizes contracted total rents due evenly over the lease term.

Advertising Costs

The Company expenses the costs of advertising, as incurred. Advertising expense was $39 3 , $3 0 6 and $326 for the years ended January 1, 2016 , December 31, 2014 and 2013, respectively.

NOTE 2 - ACCRUED LIABILITIES

Accrued liabilities consist of the following as of fiscal year ended:

	January 1, 2016	December 31, 2014
Wages and employee benefits	$ 20,687	$ 20,084
Insurance accruals	14,541	14,217
Accrued taxes	643	563
Kentucky Medicaid cost report payable	616	1,360
Accrued professional fees and other	6,037	6,102
	$ 42,524	$ 42,326

NOTE 3 - PROPERTY AND EQUIPMENT, NET

Property and equipment, net, consist of the following as of the fiscal year ended:

	January 1, 2016	December 31, 2014
Leasehold improvements	$ 2,312	$ 1,367
Medical equipment	1,561	937
Computer equipment	14,633	9,607
Internally developed software	1,744	1,071
Office and other equipment	6,369	4,502
Vehicles	162	449
	26,781	17,933
Less accumulated depreciation	(16,781)	(12,358)
	$ 10,000	$ 5,575

Depreciation and amortization expense related to property, plant and equipment is recorded in general and administrative expenses - other and was $3,321, $3,850 and $2, 594 for the years ended January 1, 2016 , December 31, 2014 and 2013, respectively.

NOTE 4 - REVOLVING CREDIT FACILITY

The Company has a senior revolving credit facility with J.P. Morgan Securities LLC as Administrative Agent, Bank of America, N.A. as Syndication Agent and certain other lenders (the "Facility"). The Facility consists of a $175 million credit line with a maturity date of November 15, 2020 and an accordion feature which permits expansion up to $250 million. Borrowings, other than letters of credit, under the credit facility generally will bear interest at a rate varying from London Interbank Offered Rate ("LIBOR") rate plus 1.75% to LIBOR rate plus 3.00% , depending on leverage. The Facility is secured by substantially all of the Company's assets and the stock of its subsidiaries. Debt issuance costs of $1.2 million are recorded in prepaid and other assets and is being amortized through November 15, 2020.

Borrowings under the Facility are subject to various covenants including a multiple of 3.5 times earnings before interest, taxes, depreciation and amortization ("EBITDA"). EBITDA may include "Acquired EBITDA" from pro-forma acquisitions as defined. Borrowings under the Facility may be used for general corporate purposes, including

acquisitions. Application of the Facility's borrowing formula as of January 1, 2016 , would have permitted $43 . 4 million to be used. We had irrevocable letters of credit totaling $11.3 million outstanding in connection with our self-insurance programs, which resulted in a total of $ 32 . 1 million being available for use at January 1, 2016 . As of January 1, 2016 , we were in compliance with the various financial covenants. Under the most restrictive of its covenants, we were required to maintain minimum net worth of at least $177.5 million at January 1, 2016 . At such date, our net worth was approximately $270.2 million.

The effective interest rates on our borrowings were 3 . 5 % and 2.7% for 2015 and 2014, respectively.

NOTE 5 - FAIR VALUE MEASUREMENTS

The Company's financial instruments consist of cash, accounts receivable, payables and debt instruments. Due to their short-term nature, the book values of cash, accounts receivable and payables are considered representative of their respective fair values. The fair value of the Company's debt instruments approximates their carrying values as substantially all of such debt instruments have rates which fluctuate with changes in market rates.

As of January 1, 2016 , the Company does not have any assets or liabilities carried at fair value that are measured on a recurring basis.

NOTE 6 - INCOME TAXES

The provision for income taxes consists of the following as of the fiscal year ended:

	January 1, 2016	December 31, 2014	December 31, 2013
Federal - current	$ 5,283	$ 2,829	$ 3,557
State and local - current	1,359	1,182	364
Deferred	3,914	5,500	2,099
	$ 10,556	$ 9,511	$ 6,020

A reconciliation of the statutory to the effective rate of the Company is as follows as of the fiscal year ended:

	January 1, 2016	December 31, 2014	December 31, 2013
Tax provision using statutory rate	35.0 %	35.0 %	35.0 %
State and local taxes, net of Federal benefit	4.4 %	4.7 %	5.7 %
Valuation allowance	0.2 %	1.0 %	-0.6%
Noncontrolling interest related	0.6 %	0.4 %	0.5 %
Legal settlement related	-5.1%	-0.1%	1.3 %
Tax provision for continuing operations	35.1 %	41.0 %	41.9 %

The Company has provided a valuation allowance against certain net deferred tax assets based upon management's estimation of realizability of those assets through future taxable income. This valuation allowance was based in large part on the Company's history of generating operating income or losses in individual tax locales and expectations for the future. The Company's ability to generate the expected amounts of taxable income from future operations to realize its recorded net deferred tax assets is dependent upon general economic conditions, competitive pressures on revenues and margins and legislation and regulation at all levels of government. There can be no assurances that the Company will meet its expectations of future taxable income. However, management has considered the above factors in reaching its conclusion that it is more likely than not that future taxable income will be sufficient to realize the deferred tax assets (net of valuation allowance) as of January 1, 2016 .

During 2015, the valuation allowance increased by $0.02 million due to a change in expected realizability of deferred tax assets.

The principal tax carry-forwards and temporary differences were as follows as of the fiscal year ended:

	January 1, 2016	December 31, 2014
Deferred tax assets		
Non-deductible reserves and allowances	$ 12,855	$ 9,853
Insurance accruals	3,431	3,174
Net operating loss carryforwards	4,550	1,484
	20,836	14,511
Valuation allowance	(1,762)	(1,746)
Total deferred tax assets	19,074	12,765
Deferred tax liabilities		
Goodwill & intangibles	(30,719)	(23,038)
Accelerated depreciation	(1,449)	(1,007)
Total deferred tax liabilities	(32,168)	(24,045)
Net deferred tax liabilities	$ (13,094)	$ (11,280)

Total net deferred tax liabilities are reflected in the accompanying balance sheet as long-term liabilities.

The Company had book goodwill of $1 13.2 million and $ 65.4 million at January 1, 2016 and December 31, 2014 , respectively, which was not deductible for tax purposes.

State operating loss carryforwards totaling $ 28.8 million at January 1, 2016 are being carried forward in jurisdictions where the Company is permitted to use tax losses from prior periods to reduce future taxable income. If not used to offset future taxable income, these losses will expire between 2016 and 2035. Due to uncertainty regarding the Company's ability to use some of the carryforwards, a valuation allowance has been established on $ 28.4 million of state net operating loss carryforwards. Based on the Company's historical record of producing taxable income and expectations for the future, the Company has concluded that future operating income will be sufficient to give rise to taxable income sufficient to utilize the remaining state net operating loss carryforwards.

US GAAP prescribes a recognition threshold and measurement attribute for the accounting and financial statement disclosure of tax positions taken or expected to be taken in a tax return. The evaluation of a tax position is a two-step process. The first step requires the Company to determine whether it is more likely than not that a tax position will be sustained upon examination based on the technical merits of the position. The second step requires the Company to recognize in the financial statements each tax position that meets the more likely than not criteria, measured at the amount of benefit that has a greater than 50% likelihood of being realized. The Company's unrecognized tax benefits would affect the tax rate, if recognized. The Company includes the full amount of unrecognized tax benefits in other noncurrent liabilities in the consolidated balance sheets. The Company anticipates it is reasonably possible an increase or decrease in the amount of unrecognized tax benefits could be made in the next twelve months. However, the Company does not presently anticipate that any increase or decrease in unrecognized tax benefits will be material to the consolidated financial statements. C hanges in unrecognized tax benefits were as follows.

	January 1, 2016	December 31, 2014	December 31, 2013
Beginning of fiscal year	$ 1,186	$ —	$ —
Increases related to positions taken on items from prior years	—	—	—
Decreases related to positions taken on items from prior years	—	—	—
Increases related to positions taken in the current year	1,284	1,186	—
Lapse of statute of limitations	—	—	—
Settlement of uncertain tax positions with tax authorities	—	—	—
Balance at end of fiscal year	$ 2,470	$ 1,186	$ —

For federal tax purposes, the Company is currently subject to examinations for tax years after 2011, while for state purposes, tax years after 2006 are subject to examination, depending on the specific state rules and regulations. The

Internal Revenue Service completed an examination of the December 31, 2011 tax year and is currently conducting an examination of Omni Home Health Holdings, Inc.'s federal tax returns for the year ended December 31, 2012 and the period ended December 6, 2013.

The Company may from time to time be assessed interest and penalties by major tax jurisdictions, although any such assessments historically have been minimal and immaterial to its financial results. Assessments for interest and/or penalties are classified in the financial statements as general and administrative - other.

NOTE 7 - STOCKHOLDERS' EQUITY

Employee Stock Incentive Plans

The Company has a 2000 Employee Stock Option Plan which initially provided for options to purchase up to 1,000 shares of the Company's common stock to key employees, officers and directors. The Board of Directors determines the amount and terms of the options, which cannot exceed ten years. At January 1, 2016 , options for 96 shares were outstanding under this plan. There are no shares available for future grant.

The 2007 Stock and Incentive Compensation Plan provided for stock awards up to 500 shares of the Company's common stock to employees, non-employee directors or independent contractors, with a maximum number of full value restricted share awards up to 200 . As of January 1, 2016 , options for 237 shares were outstanding under this plan, while 162 restricted shares had been awarded. There are no shares available for future grant.

The 2013 Stock and Incentive Compensation Plan provides for stock awards up to 700 shares of the Company's common stock to employees, non-employee directors or independent contractors. As of January 1, 2016 , options for 134 shares had been granted and were outstanding under this plan, while 192 restricted shares had been awarded. There are 374 shares available for future grant.

Historically, the Company has issued restricted share and/or option awards to employees and non-employee directors. The Board of Directors determines the amount and terms of the options, which cannot exceed ten years . Under both the 2013 and 2007 Stock and Incentive Compensation Plans, restricted share awards cliff vest on the third anniversary , while option share awards vest annually in 25% increments over four years .

Changes in award shares outstanding are summarized as follows:

	Restricted shares		Options		
	Shares	Wtd. Avg. Grant Price	Shares	Wtd. Avg. Ex. Price	Aggregate Intrinsic Value
December 31, 2012	50	$ 31.35	341	$ 25.62	$ 4,300
Granted	58	20.29	68	20.71	1,191
Vested or Exercised	(8)	19.57	(2)	12.29	(52)
Forfeited	—	—	(24)	(30.29)	(1,644)
December 31, 2013	100	$ 24.12	383	$ 24.52	5,251
Granted	61	23.27	70	24.28	977
Vested or Exercised	(39)	27.35	(13)	2.87	(460)
Forfeited	—	—	(13)	(24.57)	(816)
December 31, 2014	122	$ 22.68	427	$ 24.89	$ 5,696
Granted	100	39.97	56	37.30	52
Vested or Exercised	(45)	22.87	(12)	23.97	(171)
Forfeited	—	—	(4)	(26.35)	(258)
January 1, 2016	177	$ 32.39	467	$ 26.39	5,529

Aggregate intrinsic value represents the estimated value of the Company's common stock at the end of the period in excess of the weighted average exercise price multiplied by the number of options outstanding or exercisable.

The following table summarizes information about stock options at January 1, 2016 :

	Options Outstanding			Options Exercisable		
Range of Exercise Price	Shares	Wtd. Avg. Remaining Contractual Life	Wtd. Avg. Exercise Price	Shares	Wtd. Avg. Remaining Contractual Life	Wtd. Avg. Exercise Price
$0.00-20.00	107	1.61	$ 19.41	100	1.39	$ 19.41
$20.01-30.00	213	6.52	$ 22.92	122	5.47	$ 22.81
Over $30.00	147	5.81	$ 36.46	90	3.81	$ 35.95
	467	5.17	$ 26.39	312	3.69	$ 25.49

The following table details exercisable options and related information for year end:

	January 1, 2016	December 31, 2014	December 31, 2013
Exercisable at end of year	312	273	259
Weighted average price	$ 25.49	$ 25.59	$ 24.89
Weighted average fair value of options granted during the year	$ 12.35	$ 11.61	$ 9.59

The following table details unvested option activity for the year ended January 1, 2016 :

	Shares	Wtd. Avg. Ex. Price
December 31, 2014	154	$ 23.65
Vested	55	24.73
Granted	56	37.30
Forfeited	—	(24.08)
January 1, 2016	155	$ 28.20

The fair value of each option award is estimated on the date of grant using the Monte Carlo option valuation model with suboptimal exercise behavior. The Monte Carlo model places greater emphasis on market evidence and predicts more realistic results because it considers open form information including volatility, employee exercise behaviors and turnover. Stock options have a contractual term of 10 years. The following assumptions were used in determining the fair value of option awards for 2015 , 2014 and 2013 :

Grant date	Equivalent interest rate	Equivalent volatility	Implied expected lives
March 2, 2015	2.07 %	32.50 %	6.86
March 17, 2014	2.68 %	40.00 %	8.32
March 1, 2013	1.86 %	40.00 %	8.33

Expected volatility is based on an analysis that looks at the unbiased standard deviation of the Company's common stock over the option term as well as implied volatilities of all long-term exchange traded options for the Company. The expected life of the options represents the period of time that the Company expects the options granted to be outstanding. The risk-free rate is based on the U.S. Treasury yield curve in effect at the time of the grant of the option for the expected term of the instrument. A 0% dividend yield was assumed as no dividend payout over the term of the award is expected.

As of January 1, 2016 , there was $3,589 of total unrecognized compensation cost, after estimated forfeitures, related to unvested share-based compensation granted under the plans. That cost is expected to be recognized over a weighted-average period of 2.37 years. The total fair value of option shares vested during the years ended January 1, 2016 and December 31, 2014 was $48 7 and $446 , respectively.

Employee Stock Purchase Plan

The Company has an Employee Stock Purchase Plan ("2009 ESPP") which, if implemented, could provide employees of the Company and its subsidiaries with an opportunity to participate in the growth of the Company and to further align the interest of the employees with the interests of the Company through the purchase of shares of the Company's Common Stock. Under the 2009 ESPP, 300 shares of the Company's Common Stock have been authorized for issuance. As of January 1, 2016 , all 300 shares remain available for issuance.

NOTE 8 - RETIREMENT PLAN

The Company administers a 401(k) defined contribution retirement plan for the benefit of the majority of its employees. Employees may participate in the plan immediately upon employment. The Company matches contributions in an amount equal to one-quarter of the first 5% of each participant's contribution to the plan after completion of one year of service with the Company. 401(k) assets are held by an independent trustee, are not assets of the Company, and accordingly are not reflected in the Company's balance sheets. The Company's retirement plan expense was approximately $1,080, $910 and $550 for the years ended January 1, 2016 , December 31, 2014 , and 2013, respectively.

NOTE 9 - COMMITMENTS AND CONTINGENCIES

Operating Leases

The Company leases certain real estate, office space, and equipment under non-cancelable operating leases expiring at various dates through 202 5 and which contain various renewal and escalation clauses. Rent expense amounted to approximately $11,356, $12,846 and $8,619 for years ended January 1, 2016 , December 31, 2014 and 2013, respectively. At January 1, 2016 , minimum rental payments under these leases were as follows:

2016	$ 8,439
2017	5,930
2018	3,698
2019	2,153
2020	1,634
Thereafter	2,793
Total	$ 24,647

Legal Proceedings

From time to time, the Company is subject to various legal actions arising in the ordinary course of the Company's business, including claims for damages for personal injuries. In the Company's opinion, after discussion with legal counsel, the ultimate resolution of any of these pending ordinary course claims and legal proceedings will not have a material effect on the Company's financial position or results of operations .

The Company is in the process of complying with a civil subpoena from the United States Department of Justice received in January of 2016 related to two locations acquired along with SunCrest in late 2013. SunCrest had previously acquired the locations in its merger with Omni Home Health in 2011. The subpoena seeks the production of various pre-acquisition business records limited to certain Omni operations in Sarasota and Tampa, Florida for the years 2007-2011. The Company is cooperating fully with this investigation. The subject operations generated less than 1% of the Company's consolidated revenues in 2015.

NOTE 10 - SEGMENT DATA

At January 1, 2016 , the Company has two divisions, Home Health care and Healthcare Innovations. The Home Health care division is comprised of two reportable segments, Visiting Nurses Services (VN or Visiting Nurse) and Personal Care Services (PC or Personal Care). Healthcare Innovations is also a reportable segment.

Consistent with information given to the chief operating decision maker, the Company does not allocate certain corporate expenses to the reportable segments. These expenses are included in Unallocated below. The Company evaluates the performance of its business segments based on operating income. Intercompany and intersegment transactions have been eliminated. Segment information within the consolidated financial statements have been recast for all periods presented to conform with the new segment reporting structure.

The Company's VN segment provides skilled medical services in patients' homes largely to enable recipients to reduce or avoid periods of hospitalization and/or nursing home care. VN Medicare revenues are generated on a per episode basis rather than a fee per visit or day of care. Approximately 94% of the VN segment revenues are generated from the Medicare program, while the balance is generated from Medicaid and private insurance programs.

The Company's PC segment services are also provided in patients' homes. These services (generally provided by paraprofessional staff such as home health aides) are generally of a custodial rather than skilled nature. PC revenues are generated on an hourly basis. Approximately 83% of the PC segment revenues are generated from Medicaid and other government programs, while the balance is generated from insurance programs and private pay patients.

The Company's Healthcare Innovations business segment was created to house and separately report on our developmental activities outside the traditional home health business platform. These activities are intended ultimately, whether directly or indirectly, to benefit the Company's patients and payers through the enhanced provision of home health services. The activities all share a common goal of improving patient experiences and quality outcomes while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision.

	Fiscal Year ended		
	January 1, 2016	December 31, 2014	December 31, 2013
Net service revenues			
Home Health			
Visiting Nurse	$ 401,051	$ 380,788	$ 263,789
Personal Care	127,712	112,497	92,927
Healthcare Innovations	3,451	2,544	196
	$ 532,214	$ 495,829	$ 356,912
Operating income (loss)			
Home Health			
Visiting Nurse	$ 49,872	$ 42,899	$ 29,533
Personal Care	14,170	12,453	11,599
Healthcare Innovations	(1,217)	(13)	(482)
Unallocated	(30,722)	(30,862)	(25,857)
	$ 32,103	$ 24,477	$ 14,793
Identifiable assets			
Home Health			
Visiting Nurse	$ 310,317	$ 259,521	
Personal Care	111,524	67,238	
Healthcare Innovations	22,024	9,254	
Unallocated	20,904	9,245	
	$ 464,769	$ 345,258	
Identifiable liabilities			
Home Health			
Visiting Nurse	$ 31,570	$ 28,180	
Personal Care	24,425	19,498	
Healthcare Innovations	1,525	191	
Unallocated	133,349	64,197	
	$ 190,869	$ 112,066	
Noncontrolling Interest - Redeemable			
Healthcare Innovations	$ 3,639	$ 3,639	3,639
Capital expenditures			
Home Health			
Visiting Nurse	$ 1,388	$ 465	$ 764
Personal Care	203	149	267
Healthcare Innovations	108	—	—
Unallocated	1,418	617	1,471
	$ 3,117	$ 1,231	$ 2,502
Depreciation and amortization			
Home Health			
Visiting Nurse	$ 1,210	$ 1,250	$ 1,004
Personal Care	264	271	224
Healthcare Innovations	97	—	—
Unallocated	2,637	2,582	1,634
	$ 4,208	$ 4,103	$ 2,862

NOTE 11 — DISCONTINUED OPERATIONS

The Company follows the guidance in Accounting Standards Codification (ASC) 205-20, *Discontinued Operations* and, when appropriate, reclassifies operating units closed, sold or held for sale out of continuing operations and into discontinued operations for all periods presented. In 2013, the Company completed the sale of two Alabama locations, which operated in the VN segment. The operations and gain on sale related to the Alabama operations were reclassified from continuing operations into discontinued operations for all periods presented. The operations and any related gain on sale for these operations were reclassified from continuing operations into discontinued operations for all periods presented. The effective tax rate for discontinued operations is high in 2013 due primarily to the impact of writing off non-deductible goodwill in addition to providing a valuation allowance for Alabama net operating loss carryforwards. Unless otherwise noted, amounts in these Notes to Consolidated Financial Statements exclude amounts attributable to discontinued operations.

NOTE 12 - ACQUISITIONS

The Company completed each of the following acquisitions in pursuit of its strategy for operational expansion in the eastern United States through an expanded service base and enhanced position in certain geographic areas. The purchase price of each acquisition was determined based on the Company's analysis of comparable acquisitions, expected cash flows and arm's length negotiation with the sellers. Each acquisition was included in the Company's consolidated financial statements from the respective acquisition date.

Goodwill recognized from the acquisitions primarily relates to expected contributions of each entity to the overall corporate strategy in addition to synergies and acquired workforce, which are not separable from goodwill. Goodwill and other intangible assets generated in asset purchase transactions are expected to be amortizable for tax purposes on a straight-line basis over 15 years, unless otherwise noted. Goodwill and other intangible assets generated in stock purchase transactions are not amortizable, unless otherwise noted.

On November 5, 2015, the Company acquired the stock of Black Stone Operations, LLC ("Black Stone"). Black Stone is a provider of in-home personal care and skilled home health services in western Ohio and operates under the name "Home Care by Black Stone". The purchase price of $40 million was funded through borrowings on the Company's bank credit facility, seller notes and issuance of the Company's common stock. Black Stone's post acquisition operating results are reported in the Company's VN and PC segments and Healthcare Innovations segment.

On August 29, 2015, the Company acquired 100% of the equity of Bracor, Inc. (dba "WillCare"). Willcare, based in Buffalo, NY, owned and operated VN and PC branch locations in New York (1 2) and Connecticut (1). The purchase price was approximately $50.8 million. The transaction was funded by borrowings under the Company's bank credit facility. WillCare' s post acquisition operating results are reported in the Company's VN and PC segments.

On July 22, 2015, the Company acquired 100% of the equity of Ingenios Health Co. ("Ingenios") for approximately $11.4 million of the Company's common stock plus $2 million in cash. Ingenios is a leading provider of technology enabled in-home clinical assessments for Medicare Advantage, Managed Medicaid and Commercial Exchange lives in seven states and Washington, D.C. The post acquisition operating results of Ingenios are reported in the Company's Healthcare Innovations business segment.

On March 1, 2015, the Company acquired the stock of WillCare's Ohio operations for $3.0 million.

The following table summarizes the preliminary fair value estimates as of the respective acquisition dates of the assets acquired and liabilities assumed for the Willcare, Ingenios and Black Stone acquisitions in 2015:

	Preliminary Purchase Price Allocation
Accounts receivable	$ 13,039
Property, plant & equipment	4,654
Other assets	1,818
Goodwill	84,538
Other intangibles	10,810
Assets acquired	114,859
Liabilities assumed	(8,299)
Net assets acquired	$ 106,560

On January 29, 2015, the Company acquired a noncontrolling interest in a development stage analytics and software company, NavHealth, Inc. (NavHealth). The investment is an asset of the Company's Healthcare Innovations segment.

During 2014, the Company completed a small acquisition using cash on hand to expand existing VN segment operations.

On December 6, 2013, the Company acquired the stock of SunCrest. SunCrest and its subsidiaries owned and operated 66 Medicare-certified home health agencies and 9 private duty agencies in Florida, Tennessee, Georgia, Pennsylvania, Kentucky, Illinois, Indiana, Mississippi and Alabama. The total SunCrest purchase price for the stock was $ 76.6 million, subject to a working capital adjustment. The purchase price consisted of cash consideration of $75.1 million and a $1.5 million note payable, net of acquired cash balances of $2.2 million.

On October 4, 2013, the Company acquired 61.5% of Imperium for $5.8 million, of which $3.0 million was working capital for Imperium. Imperium is a development-stage enterprise that provides strategic health management services to ACOs. Substantially all of the purchase price was allocated to goodwill. The Company is party to a put and call arrangement with respect to the remaining 38.5% non-controlling interest in Imperium. The redemption value for both the put and the call arrangement is equal to fair value. Due to the existing put and call arrangements, the non-controlling interest is considered to be redeemable and is recorded on the balance sheet as a redeemable non-controlling interest outside of permanent equity. The redeemable non-controlling interest is recognized at the higher of 1) the accumulated earnings associated with the non-controlling interest or 2) the redemption value as of the balance sheet date.

On July 17, 2013, the Company acquired the assets of the Medicare-certified home agencies owned by IHCN. IHCN operated six home health agencies primarily in northern Indiana for a total purchase price of $12.5 million consisting of cash and $0.5 million of Almost Family, Inc. common stock. A preliminary allocation of purchase price resulted primarily in the allocation of $9.9 million to goodwill, $1.8 million to identified intangibles with the remainder primarily due to property plant and equipment and accounts receivable.

NOTE 13 - QUARTERLY FINANCIAL DATA— (UNAUDITED)

Summarized quarterly financial data are as follows for the fiscal years ended January 1, 2016 and December 31, 201 4 :

	Jan. 1, 2016	Oct. 2, 2015	Jul. 3, 2015	Apr. 3, 2015	Dec. 31, 2014	Sept. 30, 2014	Jun. 30, 2014	Mar. 31, 2014
Net service revenues	$145,217	$131,232	$127,366	$128,399	$124,756	$125,540	$125,193	$120,340
Gross margin	67,521	61,757	61,023	60,072	58,366	59,020	59,636	54,813
Net income attributable to Almost Family, Inc.	$ 2,760	$ 7,799	$ 5,010	$ 4,394	$ 4,747	$ 3,782	$ 3,961	$ 1,273
Average shares outstanding								
Basic	9,775	9,604	9,393	9,353	9,352	9,347	9,338	9,293
Diluted	10,000	9,822	9,569	9,521	9,474	9,443	9,431	9,426
Net income attributable to Almost Family, Inc. per share								
Basic	$ 0.27	$ 0.81	$ 0.53	$ 0.47	$ 0.50	$ 0.40	$ 0.42	$ 0.14
Diluted	$ 0.27	$ 0.79	$ 0.52	$ 0.46	$ 0.49	$ 0.40	$ 0.42	$ 0.14

NOTE 14 - SUBSEQUENT EVENTS

Management has evaluated all events and transactions that occurred after January 1, 2016. The following non-recognized subsequent events were noted:

On January 5, 2016, the Company acquired 100% of the equity of Long Term Solutions, Inc. (" LTS "). LTS is a provider of in-home nursing assessments for the long-term care insurance industry. LTS provides assessments in all 50 U.S. states and a number of foreign countries. The purchase price of $37 million was funded through borrowings on the Company's bank credit facility, seller notes and issuance of the Company's common stock. LTS's post acquisition operating results will be reported in the Company's Healthcare Innovations business segment.

On January 5, 2016, the Company purchased the assets of a Medicare-certified home health agency owned by Bayonne Visiting Nurse Association (Bayonne) located in New Jersey. Bayonne's post acquisition operating results will be reported in the Company's VN segment.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of Almost Family, Inc. and s ubsidiaries

We have audited the accompanying consolidated balance sheets of Almost Family, Inc. and s ubsidiaries as of January 1, 2016 and December 31, 2014, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended January 1, 2016. Our audits also included the financial statement schedule listed in the Index at Item 15(a) 2 . These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial posit ion of Almost Family, Inc. and s ubsidiaries at January 1, 2016 and December 31, 2014, and the consolidated results of their operations and their cash flows for each of the three years in the period ended January 1, 2016, in conformity with U.S. generally accepted accounting principles . Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Almost Family, Inc. and subsidiaries' internal control over financial reporting as of January 1, 2016, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated March 2, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Louisville, Kentucky
March 2, 2016

Management's Report on Internal Control over Financial Reporting

The consolidated financial statements appearing in this Annual Report have been prepared by management that is responsible for their preparation, integrity and fair presentation. The statements have been prepared in accordance with U.S. generally accepted accounting principles, which requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes.

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended). Our internal control system was designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles.

All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation. Further, because of changes in conditions, the effectiveness of an internal control system may vary over time.

Under the supervision and with the participation of our management, including our Chief Executive Officer (CEO) and Principal Financial Officer (PFO), we conducted an evaluation of the effectiveness of our internal control over financial reporting as of January 1, 2016 based on the framework in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (COSO) with the exception of the operations of WillCare Healthcare, Ingenios Health Holdings, Inc. and Black Stone Operations, LLC , which constituted 25 % of total assets as of January 2, 2016 and 6 % of net service revenues for the fiscal year then ended . Based on that evaluation, our management concluded our internal control over financial reporting was effective based on the criteria described above as of January 1, 2016.

Ernst & Young LLP, an independent registered public accounting firm, has audited and reported on the effectiveness of our internal control over financial reporting. The report of Ernst & Young LLP is contained in this Annual Report.

/s/ William B. Yarmuth	/s/ C. Steven Guenthner
William B. Yarmuth	C. Steven Guenthner
Chairman and Chief Executive Officer	President & Principal Financial Officer
Date: March 2, 2016	March 2, 2016

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of Almost Family, Inc. and s ubsidiaries

We have audited Almost Family, Inc. and s ubsidiaries' internal control over financial reporting as of January 1, 2016, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). Almost Family, Inc. and s ubsidiaries' management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Willcare HealthCare, Ingenios Health Holdings, Inc., and Black Stone Operations, LLC, which are included in the 2015 consolidated financial statements of Almost Family, Inc. and s ubsidiaries and constituted 25 % of total assets as of January 1, 2016 and 6% of net service revenues for the year then ended. Our audit of internal control over financial reporting of Almost Family, Inc. and s ubsidiaries also did not include an evaluation of the internal control over financial reporting of Willcare HealthCare, Ingenios Health Holdings, Inc., and Black Stone Operations, LLC.

In our opinion, Almost Family, Inc. and s ubsidiaries maintained, in all material respects, effective internal control over financial reporting as of January 1, 2016, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Almost Family Inc. and s ubsidiaries as of January 1, 2016 and December 31, 2014 and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended January 1, 2016 of Almost Family, Inc. and s ubsidiaries and our report dated March 2, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Louisville, Kentucky
March 2, 2016

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANT S ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURE S

Disclosure Controls and Procedures — As of January 1, 2016 , the Company's management, with participation of the Company's Chief Executive Officer and Principal Financial Officer, evaluated the effectiveness of the Company's disclosure controls and procedures as defined in Exchange Act Rules 13a-15(e) and 15d-15(e). Based on that evaluation, the Chief Executive Officer and Principal Financial Officer concluded that the Company's disclosure controls and procedures were effective as of January 1, 2016 .

Internal Control — Pursuant to Section 404 of the Sarbanes-Oxley Act of 2002, we have included a report that provides management's assessment of our internal control over financial reporting as part of this Annual Report on Form 10-K for the year ended January 1, 2016 . Management's report is included in Item 8 of this report under the caption entitled "Management's Report on Internal Control Over Financial Reporting," and is incorporated herein by reference. Our independent registered public accounting firm has issued an attestation report on the effectiveness of our internal control over financial reporting. This attestation report is included in item 8 of this report under the caption entitled "Report of Independent Registered Public Accounting Firm" and is incorporated herein by reference.

Changes in Internal Control Over Financial Reporting - There were no changes in the Company's internal control over financial reporting during the fourth quarter of 2015 , that have materially affected, or are reasonably likely to materially affect, Almost Family, Inc.'s internal control over financial reporting.

ITEM 9B. OTHER INFORMATIO N

None.

PART II I

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANC E

The information required by this Item is set forth in the Registrant's definitive proxy statement to be filed with the Commission no later than 120 days after January 1, 2016 , except for the information regarding executive officers of the Company. The information required by this Item contained in such definitive proxy statement is incorporated herein by reference.

The following table sets forth certain information with respect to the Company's executive officers.

Name	Age	Position with the Company
William B. Yarmuth (1)	63	Chairman of the Board and Chief Executive Officer
C. Steven Guenthner (2)	55	President and Principal Financial Officer
P. Todd Lyles (3)	54	Senior Vice President — Administration
Daniel J. Schwartz (4)	49	Senior Vice President and Chief Operating Officer
Rajneesh Kaushal (5)	55	Senior Vice President and Chief Clinical Officer
Jeffrey T. Reibel (6)	44	Vice President and Chief Accounting Officer

Executive officers of the Company are elected by the Board of Directors and serve at the pleasure of the Board of Directors with the exception of William B. Yarmuth who has an employment agreement with the Company. There are no family relationships between any director or executive officer.

(1) William B. Yarmuth has been a director and officer of the Company since 1991 . Mr. Yarmuth became Chairman and C hief E xecutive O fficer in 1992 ; he also served as President until the appointment of Steve Guenthner as

President in 2012. Mr. Yarmuth has served as a member of the board of directors of Industrial Services of America, Inc. since June 2014.

(2) C. Steven Guenthner has been President and Principal Financial Officer since June of 2012. Prior to which, Mr. Guenthner served as Senior Vice President and Chief Financial Officer of the Company for twenty years. From 1983 through 1992, Mr. Guenthner was employed as a C.P.A. with Arthur Andersen LLP.

(3) P. Todd Lyles joined the Company as Senior Vice President Planning and Development in 1997 and now serves as Senior Vice President — Administration. Prior to joining the Company Mr. Lyles was Vice President Development for the Kentucky Division of Columbia/HCA, a position he had held since 1993. Mr. Lyles experience also includes 8 years with Humana Inc. in various financial and hospital management positions.

(4) Daniel J. Schwartz joined the Company as Senior Vice President - Operations in April 2013, becoming Senior Vice President and Chief Operating Officer in December 2013. Mr. Schwartz's healthcare operations management experience includes previously serving as Chief Operating Officer of Addus Healthcare, Inc. from January 2011 until November 2012; owner of New Paradigm Senior Services, LLC from April 2010 until January 2011; and Senior Vice President — North American Operations for Sunrise Senior Living, Inc. from 2006 until April 2010. Mr. Schwartz served Sunrise Senior Living, Inc. a total of 15 years. Mr. Schwartz also served as chief operating officer of New Perspective Senior Living from November 2012 until joining the Company.

(5) Rajneesh Kaushal joined the company as Senior Vice President in October 2011 and now also serves as Chief Clinical Officer. Prior to joining the Company, Mr. Kaushal had served as Executive Vice President and Chief Clinical Officer for AccentCare, a national home health care company, which merged with Guardian Home Care Holdings (Guardian) in December of 2010. Mr. Kaushal joined Guardian in 2006 and his experience also includes hospital and post-acute care geriatrics.

(6) Jeffrey T. Reibel, a C.P.A., joined the Company in September of 2010 as Vice President of Finance and became Vice President and Chief Accounting Officer in 2012. Prior to joining the Company, Mr. Reibel served as Chief Executive Officer of a private compliance company he founded in 2006. Mr. Reibel's experience also includes three years as Controller and Principal Accounting Officer for a publicly traded company in addition to twelve years with Ernst & Young LLP, specializing in audits of public companies and various clients in the healthcare industry, including home health.

Code of Ethics

The Company has adopted a Code of Ethics for Senior Financial Officers that applies to its chief executive officer, principal financial officer, chief accounting officer and any person performing similar functions. The Company has made the Code of Ethics available on its website at www.almostfamily.com and will post any waivers to the Code of Ethics on the website.

ITEMS 11, 12, 13 and 14. EXECUTIVE COMPENSATIO N; SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS; CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE; AND PRINCIPAL ACCOUNTANT FEES AND SERVICES

The Registrant intends to file a definitive proxy statement with the Commission pursuant to Regulation 14A (17 CFR 240.14a) not later than 120 days after the close of the fiscal year covered by this report. In accordance with General Instruction G(3) to Form 10-K, the information called for by Items 11, 12, 13 and 14 is incorporated herein by reference to portions of the definitive proxy statement.

Equity Compensation Plans

As of January 1, 2016 , shares of common stock authorized for issuance under our equity compensation plans are summarized in the following table. See note 7 to the consolidated financial statements for a description of the plans. The table below is furnished pursuant to item 12.

Plan Category	Shares to be Issued Upon Exercise	Weighted Average Option Exercise Price	Shares Available for Future Grants
Plans approved by shareholders	466,752	$ 26.39	373,615
Plans not approved by shareholders	—	—	—
Total	466,752	$ 26.39	373,615

PART I V

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULE S

(a) The following items are filed as part of this report:

1. Index to Consolidated Financial Statements

2. Index to Financial Statement Schedule

All other Schedules have been omitted because they are either not required, not applicable or, the information has otherwise been supplied in the financial statements or notes thereto.

(b) Exhibits required to be filed by Item 601 of Regulation S-K are set forth below:

Number	Description of Exhibit
2.1	Share Purchase Agreement dated as of February 24, 2015 by and among Almost Family, Inc, National Health Industries, Inc., Bracor, Inc. and Bracor's shareholders, Summer Street Capital II, L.P., Summer Street Capital NYS Fund II, L.P., David W. Brason, Todd W. Brason and David W. Brason Multi-Generational Irrevocable Trust . (Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. Almost Family hereby undertakes to furnish supplementally copies of any of the omitted schedules upon request by the U.S. Securities and Exchange Commission.) (incorporated by reference to the Exhibit 2.1 to Registrant's Report on Form 10-K for the year ended December 31, 2014).
2.2	Stock Purchase Agreement dated as of February 24, 2015 by and among Almost Family, Inc, National Health Industries, Inc., and Bracor, Inc. (Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. Almost Family hereby undertakes to furnish supplementally copies of any of the omitted schedules upon request by the U.S. Securities and Exchange Commission.) (incorporated by reference to the Exhibit 2.1 to Registrant's Report on Form 10-K for the year ended December 31, 2014).
2.3	Closing Letter Agreement dated August 28, 2015, as amendment to Share Purchase Agreement dated as of February 2 4 , 2015 by and among Almost Family, Inc., National Health Industries, Inc., Bracor, Inc. and Bracor's shareholders, Summer Street Capital II, L.P., Summer Street Capital NYS Fund II, L.P., David W. Brason, Todd W. Brason and David W. Brason Multi-Generational Irrevocable Trust (Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. Almost Family hereby undertakes to furnish supplementally copies of any of the omitted schedules upon request by the U.S. Securities and Exchange Commission.) (incorporated by reference to Exhibit 2.2 to the Company's C urrent Report on Form 8-K filed on September 2, 2015).
2.4 *	Agreement and Plan of Merger dated as of November 3, 2015 by and among Almost Family, Inc., National Health Industries, Inc., AFAM Acquisition, LLC, Black Stone Operations, LLC, Black Stone Companies of Ohio, Inc., ERH Development, LLC, Warren County Community Services, LLC, LEC Community Services, Inc., Primrose Retirement Communities, LLC, Kimberly Payne and David Brixey. (Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. Almost Family hereby undertakes to furnish supplementally copies of any of the omitted schedules upon request by the U.S. Securities and Exchange Commission.)
2.5*	Stock Purchase Agreement dated as of January 2, 2016 by and among National Health Industries, Inc., Almost Family, Inc., Long Term Solutions, Inc., and Anne Harrington, Noreen Guanci, Noreen Guanci 2009 Irrevocable Trust and Richard Guanci 2009 Irrevocable Trust. (Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. Almost Family hereby undertakes to furnish supplementally copies of any of the omitted schedules upon request by the U.S. Securities and Exchange Commission.)
3.1	Certificate of Incorporation, as amended, of the Registrant (incorporated by reference to Exhibit No. 3.1 of the Registrant's Annual Report on Form 10-K for the year ended March 31, 1997 and Exhibit 3.1 of the Registrant's Quarterly Report Form 10-Q for the quarter ended September 30, 2008)
3.2	Amended and Restated Bylaws of the Registrant (incorporated by reference to Exhibit 3.1 of the Registrant's Current Report on Form 8-K as filed on June 8, 2012)

4.1	Form of Senior Indenture – (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on form S-3 filed on May 29, 2015, SEC File No. 333-204584.)
4.2	Form of Subordinated Indenture – (incorporated by reference to Exhibit 4.2 to the Company's Registration Statement on form S-3 filed on May 29, 2015, SEC File No. 333-204584.)
4.3	Other Debt Instruments — copies of other debt instruments for which the total debt is less than 10% of assets will be furnished to the Commission upon request.
10.1+	Employment Agreement, dated January 1, 1996, between the Company and William B. Yarmuth (incorporated by reference to Exhibit 10.24 to the Registrant's report on Form 10-K for the year ended March 31, 1996).
10.2+	2007 Stock and Incentive Compensation Plan (incorporated by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A as filed on June 25, 2007).
10.3+	Amended and Restated 2000 Stock Option Plan (incorporated by reference to Exhibit 4.1 to the Registrant's Registration Statement on Form S-8 Reg. No. 333-88744).
10.4+	Amended and Restated Non-Employee Directors Deferred Compensation Plan (incorporated by reference to the Exhibit 10.13 to Registrant's Report on Form 10-K for the year ended December 31, 2009).
10.5+	Forms of Stock Option Agreements and Restricted Stock Award Agreement pursuant to 2007 Stock and Incentive Plan (incorporated by reference to Exhibit 10.15 to the Registrant's report on Form 10-K for the year ended December 31, 2008).
10.6+	Amendment dated January 1, 2009 to Employment Agreement effective January 1, 1996, between the Registrant and William B. Yarmuth (incorporated by reference to Exhibit 10.20 to the Registrant's report on Form 10-K for the year ended December 31, 2008).
10.7+	Amendment to Amended and Restated 2000 Stock Option Plan dated January 1, 2009 (incorporated by reference to Exhibit 10.22 to the Registrant's report on Form 10-K for the year ended December 31, 2008).
10.8+	Almost Family, Inc. 2009 Employee Stock Purchase Plan (incorporated by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A as filed on July 1, 2009).
10.9	Credit Agreement, dated as of December 2, 2010 among Almost Family, Inc., the lenders party thereto, JPMorgan Chase Bank, N.A. as Administrative Agent and Bank of America, N.A., as Syndication Agent. (Incorporated by reference to Exhibit 10.1 of the Registrant's Current Report on Form 8-K dated December 2, 2010).
10.10+	2013 Stock and Incentive Plan (incorporated by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A as filed on April 4, 2013).
10.11+	Forms of Stock Option Agreement and Restricted Stock Award Agreement pursuant to 2013 Stock and Incentive Compensation Plan (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2013)

10.12+	Offer of Employment letter dated March 12, 2013, between the Registrant and Daniel Schwartz (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2013).
10.13	Third Amendment to Credit Agreement, dated as of February 12, 2015 among Almost Family, Inc., the lenders party thereto, JPMorgan Chase Bank, N.A. as Administrative Agent and Bank of America, N.A., as Syndication Agent. (i ncorporated by reference to Exhibit 10.1 of the Registrant's Current Report on Form 8-K as filed February 18, 2015).
10.14	Consolidated Amended and Restated Guaranty and Ratification Agreement dated as of February 12, 2015 (incorporated by reference to Exhibit 10.2 of the Registrant's Current Report on Form 8-K as filed February 18, 2015).
10.15	Consolidated Amended and Restated Pledge of Equity Interests dated as of February 12, 2015 (incorporated by reference to Exhibit 10.3 of the Registrant's Current Report on Form 8-K as filed February 18, 2015).
10.16	Consolidated Amended and Restated Security Agreement dated as of February 12, 2015 (incorporated by reference to Exhibit 10.4 of the Registrant's Current Report on Form 8-K as filed February 18, 2015) .
10.1 7	Second Amendment to Credit Agreement dated as of December 6, 2013 by and among Almost Family, Inc. and JPMorgan Chase Bank, N.A., for itself and as Administrative Agent under the Credit Agreement dated as of December 2, 2010 (incorporated by reference to the Exhibit 10.14 to Registrant's Report on Form 10-K for the year ended December 31, 2014).
10.1 8	Letter Agreement dated as of December 10, 2012 by and among Almost Family, Inc. and JPMorgan Chase Bank, N.A., for itself and as Administrative Agent under the Credit Agreement dated as of December 2, 2010 (incorporated by reference to the Exhibit 10. 15 to Registrant's Report on Form 10-K for the year ended December 31, 2014).
10.1 9 *	Fourth Amendment to Credit Agreement dated as of November 4 , 201 5 by and among Almost Family, Inc. and JPMorgan Chase Bank, N.A., for itself and as Administrative Agent under the Credit Agreement dated as of December 2, 2010.
21*	List of Subsidiaries of Almost Family, Inc.
23.1*	Consent of Ernst & Young LLP
31.1*	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act, as amended.
31.2*	Certification of Principal Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act, as amended.
32.1*	Certification of Chief Executive Officer pursuant to 18 U.S.C 1350, as adopted pursuant to section 906 of the Sarbanes Oxley Act of 2002.

32.2*	Certification of Principal Financial Officer pursuant to 18 U.S.C 1350, as adopted pursuant to section 906 of the Sarbanes Oxley Act of 2002.
101 *	Financial statements from the annual report on Form 10-K of Almost Family, Inc. for the fiscal year ended January 1, 2016, filed on March 2, 2016, formatted in XBRL: (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Income, (iii) Consolidated Statements of Cash Flows, (iv) Consolidated Statements of Stockholders' Equity, and (v) the Notes to Consolidated Financial Statements.

* Denotes filed herein.

+ Denotes compensatory plan or management contract.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ALMOST FAMILY, INC.

By: /s/ William B. Yarmuth March 2, 2016
William B. Yarmuth
Chairman, Chief Executive Officer

By: /s/ C. Steven Guenthner March 2, 2016
C. Steven Guenthner
President and Principal Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
By: /s/ William B. Yarmuth William B. Yarmuth	Director, Chief Executive Officer (principal executive officer)	March 2, 2016
By: /s/ C. Steven Guenthner C. Steven Guenthner	President and Principal Financial Officer	March 2, 2016
By: /s/ Jeffrey T. Reibel Jeffrey T. Reibel	Vice President of Finance and Chief Accounting Officer	March 2, 2016
By: /s/ Steven B. Bing Steven B. Bing	Director	March 2, 2016
By: /s/ Donald G. McClinton Donald G. McClinton	Director	March 2, 2016
By: /s/ Tyree G. Wilburn Tyree G. Wilburn	Director	March 2, 2016
By: /s/ Jonathan D. Goldberg Jonathan D. Goldberg	Director	March 2, 2016
By: /s/ W. Earl Reed, III W. Earl Reed, III	Director	March 2, 2016
By: /s/ Henry M. Altman, Jr. Henry M. Altman, Jr.	Director	March 2, 2016

***ALMOST FAMILY, INC.* AND SUBSIDIARIES**
VALUATION AND QUALIFYING ACCOUNTS
SCHEDULE I I
(In thousands)

Description	Col. A Balance at Beginning of Period	Col. B Additions/(Deductions) (1) Charged to Costs and Expenses	Col. C (2) Charged to Other Accounts	Col. D (3) Deductions	Col. E Balance at End of Period
Allowances:					
Year Ended January 1, 2016	$ 8,880	12,743	1,891	(6,000)	$ 17,514
Year Ended December 31, 2014	$ 15,586	$ 9,413	$ —	$ (16,119)	$ 8,880
Year Ended December 31, 2013	$ 5,236	$ 5,526	$ 8,910	$ (4,086)	$ 15,586

(1) Charged to bad debt expense.
(2) Acquired uncollectible accounts reserves, primarily SunCrest acquisition related.
(3) Write-off of accounts.

Exhibit 21

ALMOST FAMILY, INC. AND SUBSIDIARIES
LIST OF SUBSIDIARIES AS OF JANUARY 1, 2016

NAME OF ENTITY	STATE OF INCORPORATION OR ORGANIZATION
I. Almost Family, Inc. directly owned subsidiaries	
Adult Day Care of America, Inc.	Delaware
AFAM Merger, Inc.	Delaware
AFAM Acquisition, LLC	Kentucky
National Health Industries, Inc.	Kentucky
Imperium Health Management, LLC	Kentucky
Pricare ACO, LLC	Kentucky
Bluegrass Clinical Partners, LLC	Kentucky
Commonwealth Clinical Partners, LLC	Kentucky
ACO Clinical Partners, LLC	Kentucky
Bluegrass Accountable Care LLC	Kentucky
Colorado Clinical Partners, LLC	Colorado
Eastern Kentucky Clinical Partners, LLC	Kentucky
Greater Tallahassee Clinical Partners, LLC	Florida
Integrity Clinical Partners, LLC	Minnesota
Kentuckiana Clinical Partners, LLC	Kentucky
Kentucky Accountable Care LLC	Kentucky
Kentucky Clinical Partners, LLC	Kentucky
Kentucky Physicians for Accountable Care LLC	Kentucky
Physicians Accountable Care, LLC	Kentucky
Physicians Accountable Care of Kentucky LLC	Kentucky
Physicians Accountable Care of Tennessee, LLC	Tennessee
Tennessee Clinical Partners, LLC	Tennessee
Utah Clinical Partners, LLC	Utah
Western Kentucky Clinical Partners, LLC	Kentucky
Ingenios Health Holdings, Inc.	Delaware
Ingenios Health Co.	Delaware
II. National Health Industries, Inc. directly and indirectly owned subsidiaries	
AFAM Acquisition Ohio, LLC	Kentucky
Almost Family ACO Services of Kentucky, LLC	Kentucky
Almost Family ACO Services of South Florida, LLC	Florida
Almost Family PC of Ft. Lauderdale, LLC	Florida
Almost Family PC of Kentucky, LLC	Kentucky
Almost Family PC of SW Florida, LLC	Florida
Almost Family PC of West Palm, LLC	Florida
BHC Services, Inc.	New York
Black Stone Operations, LLC	Ohio
Advanced Geriatric Education & Consulting, LLC	Ohio
Blackstone Group, LLC	Ohio
Blackstone Health Care, LLC	Ohio
S&B Health Care, LLC	Ohio
Black Stone of Cincinnati, LLC	Ohio
Assisted Care by Black Stone of Cincinnati, LLC	Ohio
Home Health Care by Black Stone of Cincinnati, LLC	Ohio
Care Advisors by Black Stone, LLC	Ohio
MJ Nursing at Black Stone, LLC	Ohio
Black Stone of Dayton, LLC	Ohio
Assisted Care by Black Stone of Dayton, LLC	Ohio
Home Health Care by Black Stone of Dayton, LLC	Ohio
Black Stone of Central Ohio, LLC	Ohio
Assisted Care by Black Stone of Central Ohio, LLC	Ohio
Home Health Care by Black Stone of Central Ohio, LLC	Ohio
Black Stone of Northwest Ohio, LLC	Ohio

Assisted Care by Black Stone of Northwest Ohio, LLC	Ohio
Home Health Care by Black Stone of Northwest Ohio, LLC	Ohio
Black Stone of Northeast Ohio, LLC	Ohio
Bracor, Inc.	New York
WillCare, Inc.	New York
Litson Health Care, Inc.	New York
Western Region Health Corporation	New York
Litson Certified Care, Inc.	New York
Patient's Choice Homecare, LLC	Connecticut
Connecticut Home Health Care, Incorporated	Connecticut
Cambridge Home Health Care Holdings, Inc.	Delaware
Cambridge Home Health Care, Inc.	Ohio
Cambridge Home Health Care, Inc./Private	Ohio
Caretenders Mobile Medical Services, LLC	Ohio
Caretenders of Cleveland, Inc.	Kentucky
Caretenders of Columbus, Inc.	Kentucky
Caretenders of Jacksonville, LLC	Florida
Caretenders Visiting Services of Columbus, LLC	Ohio
Caretenders Visiting Services of District 6, LLC	Kentucky
Caretenders Visiting Services of District 7, LLC	Kentucky
Caretenders Visiting Services Employment Company, Inc.	Kentucky
Caretenders Visiting Services of Gainesville, LLC	Florida
Caretenders Visiting Services of Hernando County, LLC	Florida
Caretenders Visiting Services of Kentuckiana, LLC	Kentucky
Caretenders Visiting Services of Ocala, LLC	Florida
Caretenders Visiting Services of Orlando, LLC	Kentucky
Caretenders Visiting Services of Pinellas County, LLC	Florida
Caretenders Visiting Services of Southern Illinois, LLC	Illinois
Caretenders Visiting Services of St. Augustine, LLC	Florida
Caretenders Visiting Services of St. Louis, LLC	Missouri
Caretenders VNA of Ohio, LLC	Ohio
Caretenders VS of Boston, LLC	Massachusetts
Caretenders VS of Central KY, LLC	Kentucky
Caretenders VS of Lincoln Trail, LLC	Kentucky
Caretenders VS of Louisville, LLC	Kentucky
Caretenders VS of Northern KY, LLC	Kentucky
Caretenders VS of Ohio, LLC	Ohio
Caretenders VS of SE Ohio, LLC	Ohio
Caretenders VS of Western KY, LLC	Kentucky
IN Homecare Network Central , LLC	Indiana
IN Homecare Network North , LLC	Indiana
Mederi Caretenders VS of Broward, LLC	Florida
Mederi Caretenders VS of SE FL, LLC	Florida
Mederi Caretenders VS of SW FL, LLC	Florida
Mederi Caretenders VS of Tampa, LLC	Florida
Princeton Home Health, LLC	Alabama
OMNI Home Health Holdings, Inc.	Delaware
Omni Home Health Services, LLC	Delaware

Home Health Agency — Broward, Inc.	Florida
Home Health Agency — Brevard, LLC	Florida
Home Health Agency — Central Pennsylvania, LLC	Florida
Home Health Agency — Collier, LLC	Florida
Home Health Agency — Hillsborough, LLC	Florida
Home Health Agency — Illinois, LLC	Florida
Home Health Agency — Indiana, LLC	Florida
Home Health Agency — Palm Beaches, LLC	Florida
Home Health Agency — Pennsylvania, LLC	Florida
Home Health Agency — Philadelphia, LLC	Florida
Home Health Agency — Pinellas, LLC	Florida
OMNI Health Management, LLC	Florida
OMNI Home Health — District 1, LLC	Florida
OMNI Home Health — District 2, LLC	Florida
OMNI Home Health — District 4, LLC	Florida
OMNI Home Health — Hernando, LLC	Florida
OMNI Home Health — Jacksonville, LLC	Florida
SunCrest Healthcare, Inc.	Georgia
Almost Family ACO Services of Tennessee, LLC	Tennessee
BGR Acquisition, LLC	Florida
SunCrest Companion Services, LLC	Tennessee
SunCrest Healthcare of East Tennessee, LLC	Tennessee
SunCrest Healthcare of Middle TN, LLC	Tennessee
SunCrest Healthcare of West Tennessee, LLC	Tennessee
SunCrest Home Health of AL, LLC	Alabama
SunCrest Home Health of Central FL, LLC	Florida
SunCrest Home Health of Georgia, LLC	Georgia
SunCrest Home Health — Southside, LLC	Georgia
SunCrest Home Health of Manchester, Inc.	Tennessee
SunCrest Home Health of MO, Inc.	Missouri
SunCrest Home Health of Nashville, Inc.	Tennessee
SunCrest Home Health of North Carolina, Inc.	North Carolina
SunCrest Home Health of South GA, Inc.	Georgia
SunCrest Home Health of Tampa, LLC	Florida
SunCrest LBL Holdings, Inc.	Tennessee
Trigg County Home Health, Inc.	Kentucky
SunCrest Home Health of Claiborne County, Inc.	Tennessee
Tennessee Nursing Services of Morristown, Inc.	Tennessee
SunCrest Outpatient Rehab Services of TN, LLC	Tennessee
SunCrest Outpatient Rehab Services, LLC	Tennessee
SunCrest TeleHealth Services, Inc.	Tennessee
III. AFAM Acquisition, LLC directly and indirectly owned subsidiaries	
Patient Care, Inc.	Delaware
Patient Care Medical Services, Inc.	New Jersey
Patient Care New Jersey, Inc.	Delaware
Patient Care of Hudson County, LLC	New Jersey
Patient Care Pennsylvania, Inc.	Delaware
Priority Care, Inc.	Connecticut
Patient Care Connecticut, LLC	Connecticut

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the Registration Statements:

- Registration Statement (Form S-8 No. 333-43631) pertaining to the Non-Employee Directors Deferred Compensation Plan,
- Registration Statement (Form S-8 No. 333-88744) pertaining to the Almost Family, Inc. 2000 Stock Option Plan,
- Registration Statement (Form S-8 No. 333-149674) pertaining to the Almost Family, Inc. 2007 Stock and Incentive Compensation Plan,
- Registration Statement (Form S-8 No. 333-161484) pertaining to the Almost Family, Inc. 2009 Employee Stock Purchase Plan, and
- Registration Statement (Form S-8 No. 333-188398) pertaining to the Almost Family, Inc. 2013 Stock and Incentive Compensation Plan;
- Registration Statement (Form S-3 No. 333-204584) of Almost Family, Inc.;

of our reports dated March 2, 2016, with respect to the consolidated financial statements and schedule of Almost Family, Inc. and Subsidiaries and the effectiveness of internal control over financial reporting of Almost Family, Inc. and Subsidiaries included in this Annual Report (Form 10-K) of Almost Family, Inc. for the year ended January 1, 2016.

/s/ Ernst & Young LLP

Louisville, Kentucky
March 2 , 2016

Exhibit 31.1

CERTIFICATIONS OF CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT

I, William B. Yarmuth, certify that:

1. I have reviewed this annual report on Form 10-K of Almost Family, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 2 , 2016

By /s/ William B. Yarmuth
William B. Yarmuth
Chairman of the Board, Chief Executive Officer

Exhibit 31.2

CERTIFICATIONS OF PRINCIPAL FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT

I, C. Steven Guenthner, certify that:

1. I have reviewed this annual report on Form 10-K of Almost Family, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 2 , 2016

By /s/ C. Steven Guenthner
C. Steven Guenthner
President and Principal Financial Officer

Exhibit 32.1

CERTIFICATIONS OF CHIEF EXECUTIVE OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350
(AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002)

I, William B. Yarmuth, Chief Executive Officer of Almost Family, Inc. (the "Company"), certify, pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, 18 U.S.C. Section 1350, that:

(1) The Annual Report on Form 10-K of the Company for the annual period ended January 1, 2016 (the "Report") fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78m); and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: March 2 , 2016

By /s/ William B. Yarmuth
William B. Yarmuth
Chairman of the Board, Chief Executive Officer

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

Exhibit 32.2

CERTIFICATIONS OF PRINCIPAL FINANCIAL OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350
(AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002)

I, C. Steven Guenthner, Principal Financial Officer of Almost Family, Inc. (the "Company"), certify, pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, 18 U.S.C. Section 1350, that:

(1) The Annual Report on Form 10-K of the Company for the annual period ended January 1, 2016 (the "Report") fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934 (15 U.S.C. 78m); and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: March 2 , 2016

By /s/ C. Steven Guenthner
C. Steven Guenthner
President & Principal Financial Officer

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

Attachment C, Contribution to the Orderly Development Of Health Care - 4-A

Department of Health License

Board for Licensing Health Care Facilities

State of Tennessee License No. 0000000093

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

TENNESSEE NURSING SERVICE OF MORRISTOWN, INC. *to conduct and maintain a*

Home Care Organization SUNCREST HOME HEALTH

Located at 657 BROADWAY BLVD., SUITE C, JEFFERSON CTY

County of JEFFERSON *, Tennessee.*

This license shall expire NOVEMBER 02 , 2017 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 15TH *day of* SEPTEMBER , 2016 .

In the Distinct Category(ies) of:

SKILLED NURSING
PHYSICAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL SERVICES
HOME HEALTH AID SERVICES
HOME HEALTH AGENCY
OTHER SPECIALTY
HOMEMAKERS SERVICES
OCCUPATIONAL THERAPY

By Vincent J. Dawson, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner MD
COMMISSIONER

CF012

Attachment C, Contribution to the Orderly Development Of Health Care

Proof of Publication

CLAIBORNE, CAMPBELL, COCKE, GRAINGER, HAMBLEN, JEFFERSON, UNION COUNTIES.

Attn:
To: WALLER LANSDEN DORTCH & DAVIS, LLP

(Advertising) NOTIFICATION OF INTENT TO APPLY FOI

P.O.#:

PUBLISHER'S AFFIDA

State of Tennessee }
S.S
County of Knox }

Before me, the undersigned, a Notary Public in and for said c
Watkins first duly sworn, according to law, says that he/she is
Knoxville News-Sentinel, a daily newspaper published at Kn
the advertisement of:

(The Above-Referenc

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that:

Tennessee Nursing Service of Morristown, Inc. d/b/a SunCrest Home Health, a home health agency owned by: SunCrest Home Health of Claiborne County, Inc., with an ownership type of corporation, and to be managed by itself, intends to file an application for a Certificate of Need for relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately $100,000.

The anticipated date of filing the application is: December 15 , 2016.

The contact person for this project is Kim H. Looney, Esq., Attorney, who may be reached at: Waller Lansden Dortch & Davis LLP 511 Union Street, Suite 2700, Nashville TN 37219, (615) 850-8722.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

of which the annexed is a copy, was published in said paper on the following date(s):

12/10/2016

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Louise Watk

Subscribed and sworn to before me this 12 day of Dec 20 16

Karen Dixon

Notary Public

My commission expires _____ 20____

MY COMMISSION EXPIRES: June 26, 2017

KAREN DIXON
STATE OF TENNESSEE
NOTARY PUBLIC
BLOUNT COUNTY

CLAIBORNE, CAMPBELL, COCKE, GRAINGER, HAMBEN, JEFFERSON, UNION COUNTIES.

Attn:
To: WALLER LANSDEN DORTCH & DAVIS, LLP

(Advertising) NOTIFICATION OF INTENT TO APPLY FOI

P.O.#:

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that:

Tennessee Nursing Service of Morristown, Inc. d/b/a SunCrest Home Health,

PUBLISHER'S AFFIDA

State of Tennessee }

s.s

County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day personally came Louise Watkins first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of:

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following date(s):

12/10/2016

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Louise Watk

Subscribed and sworn to before me this 12 day of Dec 20 16

Karen Dixon

Notary Public

My commission expires MY COMMISSION EXPIRES: June 26, 2017 20

KAREN DIXON
STATE OF TENNESSEE
NOTARY PUBLIC
BLOUNT COUNTY

Knoxville News Sentinel

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that:

Tennessee Nursing Service of Morristown, Inc. d/b/a SunCrest Home Health, a home health agency owned by: SunCrest Home Health of Claiborne County, Inc., with an ownership type of corporation, and to be managed by itself, intends to file an application for a Certificate of Need for relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately $100,000.

The anticipated date of filing the application is: December 15 , 2016.

The contact person for this project is Kim H. Looney, Esq., Attorney, who may be reached at: Waller Lansden Dortch & Davis LLP 511 Union Street, Suite 2700, Nashville TN 37219, (615) 850-8722.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

PROOF OF PUBLICATION

Acct. Name:

WALLER LANSDEN DORTC

Acct. # 263672

COST OF PUBLICATION

Total $355.79

STATE OF TENNESSEE

COUNTY OF GREENE

PERSONALLY appeared before me TKA

_____ of Greene County, Tennessee.

who being duly sworn, made oath that he/she is a representative of the Publisher of THE GREENEVILLE SUN, a newspaper of general circulation, published in the City of Greeneville, County of Greene and State of Tennessee and that the hereto attached publication appeared in the same on the following dates:

NOTIFICATION OF INTENT T

12/10/2016

The Greeneville Sun

P.O. BOX 1630, GREENEVILLE, TN 37744

(423) 638-4181

Subscribed and sworn to before me on this 7th day of December, 2016

JANET L. MEDCALF STATE OF TENNESSEE NOTARY PUBLIC GREENE COUNTY

Newspaper Representative: TKA

Notary Public: Janet L Medcalf

My Commission Expires: 6/28/20

The referenced publication of notice has also been posted (1) On the newspaper's website, where it shall be published contemporaneously with the notice's first print publication and will remain on the website for at least as long as the notice appears in the newspaper; and (2) On a statewide web site established and maintained as an initiative and service of the Tennessee Press Association as a repository for such notices.

The Greeneville Sun
Classifie
Place your ad by calling 423.638.4185 Fax to 423.638.7348 • Online at Greenev

Public Notices

Public Notices

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that: Tennessee Nursing Service of Morristown, Inc. d/b/a SunCrest Home Health, home health agency owned by: SunCrest Home Health of Claiborne County, Inc. with an ownership type of corporation and to be managed by: itself intends to file an application for a Certificate of Need for relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing services area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately $100,000.

The anticipated date of filing the application is: December 15, 2016

The contact person for this project is Kim H. Looney, Esq. who may be reached at: Waller Lansden Dortch & Davis LLP, 511 Union Street, Suite 2700, Nashville, TN 37219 615/850-8722.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to: Health Services and Development Agency, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, Tennessee 37243.

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.
12/10/16

1 PUBLIC NOTICES

Public Notices

NOTICE**NOTICE**NOTICE

The Greeneville Sun Classified Department would like to remind our customers to beware of scams. Please do not give out any financial information to anyone that makes a follow up call on

Public Notices

IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE THIRD JUDICIAL DISTRICT, SITTING AT GREENEVILLE (PROBATE DIVISION)

NOTICE TO CREDITORS

ESTATE OF HAZEL EDNA BROWN, DECEASED (Case # 2016-PR-245)

Pursuant to T.C.A. 30-2-306, notice is hereby given that on the 21st day of November, 2016, Letters Testamentary, in respect to the estate of Hazel Edna Brown, who died on the 18th day of February, 2016, were issued to the undersigned by the Chancery Court of Greene County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured against the estate are required to file the same with the Clerk & Master of the above named court on or before the earlier of the dates prescribed in (1) or (2), otherwise their claims will be forever barred:

(1) (A) Four (4) months from the date of the first publication (or posting, as the case may be) of this Notice if the creditor received an actual copy of this Notice to Creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or

(B) Sixty (60) days from the date the creditor received an actual copy of the Notice to Creditors if the creditor received the copy of the Notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1)(A); or
(2) Twelve (12) months from the decedents date of death.

This the 21st day of November, 2016

Signed Jaqueline B. Grubb, Co-Personal Representative
Signed Daniel M. Brown, Co-Personal Representative
Attorney for the Estate: Ronald W. Woods, Esquire
Kay Solomon Armstrong, J.D., Clerk and Master
Greene County Chancery Court Probate Division
101 South Main Street, Suite 104
Greeneville, TN 37743
423-798-0010 or 1744
12/3/16, 12/10/16

IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE THIRD JUDICIAL DISTRICT

Public Notices

IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE THIRD JUDICIAL DISTRICT, SITTING AT GREENEVILLE (PROBATE DIVISION)

NOTICE TO CREDITORS

ESTATE OF GEORGIA KATE EALEY, DECEASED (Case # 2016-PR-249)

Pursuant to T.C.A. 30-2-306, notice is hereby given that on the 29th day of November, 2016, Letters of Administration, in respect to the estate of Georgia Kate Ealey, who died on the 19th day of August, 2016, were issued to the undersigned by the Chancery Court of Greene County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured against the estate are required to file the same with the Clerk & Master of the above named court on or before the earlier of the dates prescribed in (1) or (2), otherwise their claims will be forever barred:
(1) (A) Four (4) months from the date of the first publication (or posting, as the case may be) of this Notice if the creditor received an actual copy of this Notice to Creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the Notice to Creditors if the creditor received the copy of the Notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1)(A); or
(2) Twelve (12) months from the decedents date of death.

This the 29th day of November, 2016

Signed Scot Edward Rush, Administrator
Attorney for the Estate: Jeffrey A. Cobble, Esquire
Kay Solomon Armstrong, J.D., Clerk and Master
Greene County Chancery Court Probate Division
101 South Main Street, Suite 104
Greeneville, TN 37743
423-798-0010 or 1744
12/3/16, 12/10/16

IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE THIRD JUDICIAL DISTRICT, SITTING AT GREENEVILLE (PROBATE DIVISION)

Public Notic

IN THE CHANCERY CO
THE STATE OF TENN
THIRD JUDICIAL DIS
SITTING AT GREENI
(PROBATE DIVIS

NOTICE TO CREDITORS

ESTATE OF ZELLA LEE
DECEASED (Case # 2016

Pursuant to T.C.A. 30-2-3
hereby given that on the
December, 2016, Letters
tary, in respect to the est
Lee Broyles, who died
day of September, 2016,
to the undersigned by th
Court of Greene County,
All persons, resident ar
dent, having claims, mat
matured against the est
quired to file the same wi
& Master of the above n
on or before the earlier
prescribed in (1) or (2), oth
claims will be forever barre

(1) (A) Four (4) months fr
of the first publication (or p
the case may be) of this
creditor received an act
this Notice to Creditors a
(60) days before the date
(4) months from the date
publication (or posting); or
(B) Sixty (60) days from
creditor received an actua
the Notice to Creditors if
received the copy of the N
than sixty (60) days prior
that is four (4) months fror
of first publication (or pos
scribed in (1)(A); or
(2) Twelve (12) month
decedents date of death.

This the 6th day of Decem

Signed Patricia Ann E
ecutrix
Attorney for the Estate:
King, Jr., Esquire
Kay Solomon Armstrong,
and Master
Greene County Chancery
bate Division
101 South Main Street, Su
Greeneville, TN 37743
423-798-0010 or 1744
12/10/16, 12/17/16

2 ANNOUNCE

Lost and Fou

PROOF OF PUBLICATION

Acct. Name:

WALLER LANSDEN DORTC

Acct. # 263669

COST OF PUBLICATION

Total $127.00

STATE OF TENNESSEE

COUNTY OF HAWKINS

PERSONALLY appeared before me Tommy Campbell

_____ of Hawkins County, Tennessee.

who being duly sworn, made oath that he/she is a representative of the Publisher of THE ROGERSVILLE REVIEW, a newspaper of general circulation, published in the City of Rogersville, County of Hawkins and State of Tennessee and that the hereto attached publication appeared in the same on the following dates:

HAWKINS COUNTY(ALMOST FM)

12/10/2016

The Rogersville Review

P.O. BOX 100, ROGERSVILLE, TN 37857

(423) 272-7422

Subscribed and sworn to before me on this 9th day of December, 2016

Newspaper Representative: [signature]

Notary Public: Sharon F Roberts

My Commission Expires: May 06, 2018

SHARON F. ROBERTS STATE TENNESSEE NOTARY PUBLIC COUNTY OF HAWKINS

The referenced publication of notice has also been posted (1) On the newspaper's website, where it shall be published contemporaneously with the notice's first print publication and will remain on the website for at least as long as the notice appears in the newspaper; and (2) On a statewide web site established and maintained as an initiative and service of the Tennessee Press Association as a repository for such notices.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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Tennessee Nursing Service of Morristown, Inc. d/b/a SunCrest Home Health, a home health agency owned by: SunCrest Home Health of Claiborne County, Inc., with an ownership type of corporation, and to be managed by itself, intends to file an application for a Certificate of Need for relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately $100,000.

The anticipated date of filing the application is: December 15 , 2016.

The contact person for this project is Kim H. Looney, Esq., Attorney, who may be reached at: Waller Lansden Dortch & Davis LLP 511 Union Street, Suite 2700, Nashville TN 37219, (615) 850-8722.

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Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.
1x 12/10/2016

1339010

KINGSPORT TIMES-NEWS

PUBLICATION CERTIFICATE

Kingsport, TN 12/12/16

This is to certify that the Legal Notice hereto attached was published in the Kingsport Times-News, a daily newspaper published in the City of Kingsport, County of Sullivan, State of Tennessee, beginning in the issue of December 10, 2016, and appearing 1 consecutive weeks/times, as per order of Waller, Lansden, Dortch & Davis

Signed Sheryl Edwards

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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PUB1T: 12/10/16

STATE OF TENNESSEE, SULLIVAN COUNTY, TO-WIT:

Personally appeared before me this 12th day of December 2016, Sheryl Edwards of the Kingsport Times-News and in due form of law made oath that the foregoing statement was true to the best of my knowledge and belief.

STATE TENNESSEE NOTARY PUBLIC WASHINGTON COUNTY

Janice Reese
NOTARY PUBLIC

My commission expires 4-6-20

KINGSPORT TENNESSEE TimesNews

Order Confirmation

Ad Order Number	Customer	Payor Customer
0001339010	WALLER LANSDEN DORTCH & D	WALLER LANSDEN DORTCH & DA
Sales Rep.	**Customer Account**	**Payor Account**
sedwards	1081099	1081099
Order Taker	**Customer Address**	**Payor Address**
sedwards	511 UNION ST., SUITE 2700 NASHVILLE TN 37219 USA	511 UNION ST., SUITE 2700 NASHVILLE TN 37219 USA
Ordered By		
	Customer Phone	**Payor Phone**
Order Source	615-850-8807	615-850-8807
PO Number	**Customer Fax**	**Customer EMail**
		laurie.glass@wallerlaw.com

Tear Sheets	Proofs	Affidavits	Payment Method
0	0	1	

Invoice Text:

Blind Box	Materials	Color
		<NONE>

Net Amount	Tax Amount	Total Amount	Payment Amt	Amount Due
$167.53	$0.00	$167.53	$0.00	$167.53

Ad Number	Ad Type	Ad Size	Pick Up Number
0001339010-01	XLegal Liner	2.0 X 51 Li	

External Ad #

Ad Attributes

Run Dates 12/10/2016

KINGSPORT TENNESSEE
TimesNews

Order Confirmation

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Attorney, who may be reached at: Waller Lansden Dortch & Davis LLP, 511 Union Street, Suite 2700, Nashville, TN 37219, 615/850-8722

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Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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PUB1T: 12/10/16

513478

VENDOR NO: TEN008 950-82 NAME: TENNESSEE HEALTH SERVICES AND DEVELOPMENT CHECK DATE: 12/14/2016

REFERENCE	INVOICE DATE	GROSS AMOUNT	DISCOUNT TAKEN	NET AMOUNT PAID
12/12/16	12/12/2016	15,000.00	0.00	15,000.00
TOTAL >		15,000.00	0.00	15,000.00

ORIGINAL CHECK HAS A COLORED BACKGROUND PRINTED ON WHITE PAPER AND A MICRO PRINT BORDER

ALMOSTfamily
Excellence Through SeniorAdvocacy

Almost Family, Inc.
9510 Ormsby Station Road, Suite 300
Louisville, KY 40223
(502) 891-1000
www.almostfamily.com

JP Morgan CHASE NA
P.O. Box 1045
Columbus, OH
43271-1045
56-1544 / 441

513478

DATE 12/14/2016
AMOUNT ***15,000.00

Void after 90 days

PAY ******Fifteen Thousand and 00/100******

TO THE ORDER OF
TENNESSEE HEALTH SERVICES AND DEVELOPMENT
502 DEADERICK STREET
NASHVILLE, TN 37243

⑈513478⑈ ⑆044115443⑆ 616285748⑈

DEC 15 '16 PM4:14

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

Kim H. Looney, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Kim H. Looney
SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of December, 2016, a Notary Public in and for the County/State of Tennessee.

Laurie A. Glass
NOTARY PUBLIC

My commission expires January 8, 2019.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JANUARY 8, 2019

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

February 1, 2017

Kim Looney, Esq.
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219

RE: Certificate of Need Application -- Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health - CN1612-042
The relocation of the applicant's principal office from 409 Cawood Road, Tazewell (Claiborne County), to 657 Broadway, Suite C, Jefferson City (Jefferson County), TN. The service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan, and Union Counties. The estimated project cost is $306,432.

Dear Ms. Looney:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 30-day review cycle for **CONSENT CALENDAR** for this project will begin on February 1, 2017. The first thirty (30) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the thirty (30)-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on April 26, 2017.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: February 1, 2017

RE: Certificate of Need Application
Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health - CN1612-042
CONSENT CALENDAR

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a **CONSENT CALENDAR** thirty (30) day review period to begin on February 1, 2017 and end on March 1, 2017.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Kim Looney, Esq.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the The Greeneville Sun (Greene); The Rogersville Review (Hawkins and Hancock); Kingsport Times News (Sullivan); Knoxville News Sentinel (Claiborne, Campbell, Cocke, Grainger, Hamblen, Jefferson and Union counties) (Name of Newspaper) which are newspapers of general circulation in Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties, (County) Tennessee, on or before December 10, (Month/Day) 20 16 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health (Name of Applicant) home health agency (Facility Type-Existing)
owned by: SunCrest Home Health of Claiborne County, Inc. with an ownership type of corporation
and to be managed by: itself intends to file an application for a Certificate of Need
for : relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately $100,000.

The anticipated date of filing the application is: December 15, 20 16
The contact person for this project is Kim H. Looney, Esq. (Contact Name) Attorney (Title)
who may be reached at: Waller Lansden Dortch & Davis LLP (Company Name) 511 Union Street, Suite 2700 (Address)
Nashville (City) TN (State) 37219 (Zip Code) 615 (Area Code) / 850-8722 (Phone Number)
Kim H. Looney (Signature) December 9, 2016 (Date) Kim.Looney@wallerlaw.com (Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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Supplemental- #1
-Original-

Tennessee Nursing Services of Morristown

CN1612-042

waller

SUPPLEMENTAL #1
January 27, 2017
10:10am

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 27, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc.
CN1612-042

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated December 21, 2016, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. Section A., Applicant Profile, Item A.1. Facility Address

The applicant provided the address of the current location. Please provide the address of the proposed new location and submit a replacement page.

Response: The proposed new location is 657 Broadway, Suite C, Jefferson City (Jefferson County), Tennessee 37760-4949 (see also replacement page 1 included as Attachment Section A, Applicant Profile-A-1.

2. Section A., Executive Summary A, Item A

Please clarify if the applicant will be surrendering the CON specific to the 409 Cawood Road, Tazewell, TN location.

Response: The applicant is relocating its principal office for the existing services to the 657 Broadway, Suite C, Jefferson City, TN branch office location. It will no longer operate an office at 409 Cawood Road in Tazewell for home health services. (When the home health agency was licensed, the CON merged into the license). Additionally, the Jefferson City location is close to a major highway, whereas Tazewell is not centrally located. Because Jefferson City is currently a branch office and Tazewell is the parent office of the home health agency, both can

and access to service will not change or be negatively affected with the approval of this project.

3. Section A., Executive Summary A, Item C, Consent Calendar Justification

The Consent Calendar Justification letter could not be found. If applicable, please briefly specify the reasons for requesting Consent Calendar by addressing each of the four criteria: 1) Need, 2) Economic Feasibility, and 3) Contribution to the Orderly Development of Health Care, and 4) Quality Measures.

Response: The request to be placed on the consent calendar was filed the same day as the application. An updated Consent Calendar Justification letter filed on January 26, 2017, is included as Attachment A, Executive Summary-Item C.

4. Section A, Project Details, Item 4 B. (1) Plot Plan

As required for all projects, a Plot Plan must provide **the size of the site (in acres), location of the structure on the site, the location of the proposed construction, and the names of streets, roads, highways that cross or border the site**. Please provide a new Plot Plan with all the required information.

Response: Please see plot plan included as Attachment Section A, Project Details, Item 4-B.1. The applicant currently operates a branch office at the proposed location. As shown on the attached plot plan, the existing building in Broadway Plaza is on plot number 82.02, which consists of 2.34 acres. The applicant is currently located in Suite C and will continue to be located in this same suite upon relocating its principal office into the existing branch office space. The building borders U.S. Highway 11E. The applicant occupies 4,123 square feet.

A question came up verbally about whether or not the applicant had discontinued using the space in Jefferson City as its principal office. (Please recall from the application that the applicant applied for and received all approvals were granted necessary to effect this change, including a new license. It was only after these approvals that it received notification that it should have applied for and received CON approval prior to the change taking place.) The applicant currently is using the Jefferson City location as a branch office and the location at 409 Cawood Road in Tazewell is being operated as the principal office. Upon approval of this application, the applicant will operate the proposed location as the principal office and the location in Tazewell will no longer be used for home health services.

5. Section A, Project Details, Item 4 B. (2) Floor Plan

Please provide a floor plan as referenced in Attachment 6B-2.

Response: Please see floor plan included as Attachment Section A, Project Details, Item 6B-2. The applicant currently leases 4,123 square feet of space. The floor plan is in several drawings that have the square footage identified. Two of the drawings show furniture location in the leased office space. All of the space is office and conference room space; none of the areas is used for patient care.

6. Section B, Need, Item 2.a. and 2.b (Project Specific Criteria-Construction, Renovation, Expansion and replacement of Health Care Institutions)

Please address #2.a and #2.b. of the Project Specific Criteria-Construction, Renovation, Expansion and replacement of Health Care Institutions.

Response: Please see response below.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. For relocation or replacement of an existing licensed health care institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

Response: In this situation, the applicant does not need to renovate its existing space, and there would be no benefits provided if it did. It has determined that relocating the principal office will allow services to be provided more efficiently as well as result in a cost savings. Instead of having 3 locations to provide the necessary home health services, with 2 being branch offices and one being the principal office, the applicant will have 1 branch office and one principal office as a result of the approval of this application. This consolidation makes sense, both from a health planning perspective as well as efficiency and cost savings perspectives.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response: The applicant is an existing licensed home health agency. The relocation of its principal office should have no significant effect on the demand for its services; as an operating home health agency, the demand already exists.

7. Section B, Need, Item 4A. (Proposed Service Area)

It appears the Projected Population Year in the population table on page 20 of the application is 2020. However, it is unclear what year is designated for the current year. Please use the year 2016 for the current year and revise the table if necessary.

Response: The table has been revised to account for 2016 projected population data from the Department of Health/Health Statistics. See revised page 20 included as Attachment Section B, Need-Item 4A.

8. Section B, Need, Item 6.

Please respond to item 6 on page 21. This question is required for all projects.

Response: The utilization for each of the past 3 years, as provided on the Historical Data Chart is included below, along with an estimate for projected utilization for 2017 and 2018. The applicant applied a conservative growth rate of 3%.

Number of Visits

2014	29,323
2015	28,316
2016	29,806
2017	30,700
2018	31,621

9. Section B, Economic Feasibility, Item 1.

It is noted the applicant already operates the office proposed as the principal office as a branch office. However, in Section B of the Project Costs Chart, please designate the fair market value of the space assigned to the applicant's proposed new home health business location or the total amount of lease payments over the initial term of the lease, whichever is greater.

Response: The applicant has included the assessed value of the entire leased space on the revised Project Costs Chart. The assessed value of 4,123 square feet leased by the applicant has been multiplied by the value of $59.77 per square foot for a cost of $246,432. Please see replacement page 23, Project Costs Chart, and the record from the tax assessor's office which shows the value of the building and land, included as Attachment Section B, Economic Feasibility, Item 1.

10. Section B, Economic Feasibility, Item 2. Funding

It is noted the proposed project will be funded through cash reserves. However the funding documentation from the applicant's Vice President and Secretary does not state the proposed project will be funded with cash reserves. Please revise.

Response: Please see revised letter that has been executed by both Todd Lyles, Sr. Vice President and Secretary for Tennessee Nursing Services of Morristown, Inc., and William Yarmuth, Chairman and CEO of Almost Family, Inc., its parent company included as Attachment Section B, Economic Feasibility-Item 2.

11. Section B. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

Please complete a Historical and Projected Data Chart for the proposed project.

Response: The Historical Data Chart on pages 25 and 26 and Projected Data Chart on pages 28 and 29 are included as Attachment Section B, Economic Feasibility-4-Q.11.

12. Section B. Economic Feasibility Item 5.A

Please complete the table for Gross Charge, Deductions from Revenue, and Average Net Charge (use figures from the Historical and Projected Data Charts).

Response: Please see revised page 30 to include completion of table for Gross Charge, Deductions from Revenue and Average Net Charge, based on the Historical and Projected Data Charts, included as Attachment Section B, Economic Feasibility-Item 5.A. The average net charge for 2015 compares favorably with that of similar facilities in the service area, and is the median of the charges compared.

13. Section B. Economic Feasibility Item 6.B and 6.C.

Please provide a response to 6 (B.) (Net Operating Margin Ratio) and 6 (C) (Capitalization Ratio).

Response: Please see revised page 31 included as Attachment Section B, Economic Feasibility-Item 6.B and 6.C, which includes the completed net operating margin ratio table. There is no capitalization ratio.

14. Section B. Economic Feasibility Item 7.

The payor mix table is noted. Please complete by using the applicant's Projected Data Chart Year One figures and submit.

Response: Please see revised page 32, included as Attachment Section B, Economic Feasibility-Item 7.

15. Section B. Economic Feasibility Item 8 A. and 8. B.

The staffing tables on page 33 of the application are noted. However, please complete the columns for "Average Wage (Contractual Rate)" and "Area Wide/Statewide Average Wage" and submit.

Response: Please see revised page 33 included as Attachment Section B, Economic Feasibility-Item 8A and 8B.

16. **Section B. Orderly Development Item 1.**

List all existing health care provider (i.e. hospitals, using homes, home care organizations etc.) managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as transfer agreements, contractual agreements for health services.

Response: The applicant has relationships with many area hospitals, nursing homes, assisted living facilities and physicians. Included below are some of those relationships:

Asbury Place at Steadman Hill
Bristol Regional Medical Center
Broadmore Senior Living
Brookdale Assisted Living
Brookdale Senior Living
Elmcroft of Kingsport
Hancock County Hospital
Jefferson County Nursing Home
Lafollette Court Assisted Living Center
Laughlin Memorial Hospital
Laurel Manor Health Care
Life Care Center
Morristown Hamblen Hospital
NHC Healthcare
Signature Healthcare
Tennova Jefferson Memorial Hospital
Tennova Lafollette Medical Center
The Cambridge House
The Village at Allandale
Wexford House

17. **Section B. Orderly Development Item 4.**

Please provide documentation of Joint Commission accreditation.

Response: Please see copy of Joint Commission accreditation letter included as Attachment Section B, Orderly Development-Item 4.

waller

18. Section B. Orderly Development Item 4B. and 4C.

It is noted there were no deficiencies as a result of the most recent survey. Please provide a letter from the appropriate agency documenting there were no deficiencies.

Response: Please see letter from Karen Kirby, Regional Administrator, of the Office of Licensure and Regulation, East Tennessee Region noting no deficiencies were found after a recertification survey included as Attachment Section B, Contribution to the Orderly Development of Healthcare, Item 4B and 4C-Q.18.

Section B. Orderly Development, Project Completion Forecast Chart.

Please complete the Project Completion Forecast Chart

Response: Please see revised page 41 - Project Completion Forecast Chart included as Attachment Section B, Contribution to the Orderly Development of Healthcare-Q19.

Please contact me if you have any questions or need additional information.

Sincerely,

Kim Harvey Looney

KHL:lag

Attachments

Attachment Section A, Applicant Profile-Item A-1

Replacement Page 1

SUPPLEMENTAL #1
January 27, 2017
10:10am

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. ***Name of Facility, Agency, or Institution***

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
Name

657 Broadway, Suite C — Jefferson
Street or Route — County

Jefferson City — TN — 37760-4949
City — State — Zip Code

Website address: N/A

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. ***Contact Person Available for Responses to Questions***

Kim H. Looney, Esq. — Attorney
Name — Title

Waller Lansden Dortch & Davis LLP — kim.looney@wallerlaw.com
Company Name — Email address

511 Union Street, Suite 2700 — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Attorney — 615-850-8722 — 615-244-6804
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

SUPPLEMENTAL #1
January 27, 2017
10:10am

Attachment Section A, Executive Summary-Item C

Consent Calendar Justification Letter

waller

JAN 26 '17 AM10:53

SUPPLEMENTAL #1

January 27, 2017
10:10am

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 27[illegible] Main
P.O. Box 198966 615.244.6804 fax
Nashville, TN 37219-8966 wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 26, 2017

VIA HAND DELIVERY

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
CN1612-042

Dear Melanie:

Please be advised that the applicant requests that the application be placed on the consent calendar. The applicant would expect no opposition to this project since it is not adding any counties to its service area. The applicant does not expect that the proposed relocation of its principal office would affect the criteria of need or quality measures as the applicant intends to continue to operate in the same service area, offering the same high quality level of services following the relocation. The criteria of economic feasibility could be affected by this proposed relocation insofar as the relocation will allow the applicant to reduce overhead by cutting back on administrative and leasing costs. Furthermore, a positive effect may occur with respect to the orderly development of health care in that the proposed relocation will place the principal office of the project in Jefferson County, the county with the highest projected population growth from 2016 to 2020.

If you have any questions or need any additional information, please do not hesitate to call me.

Sincerely,

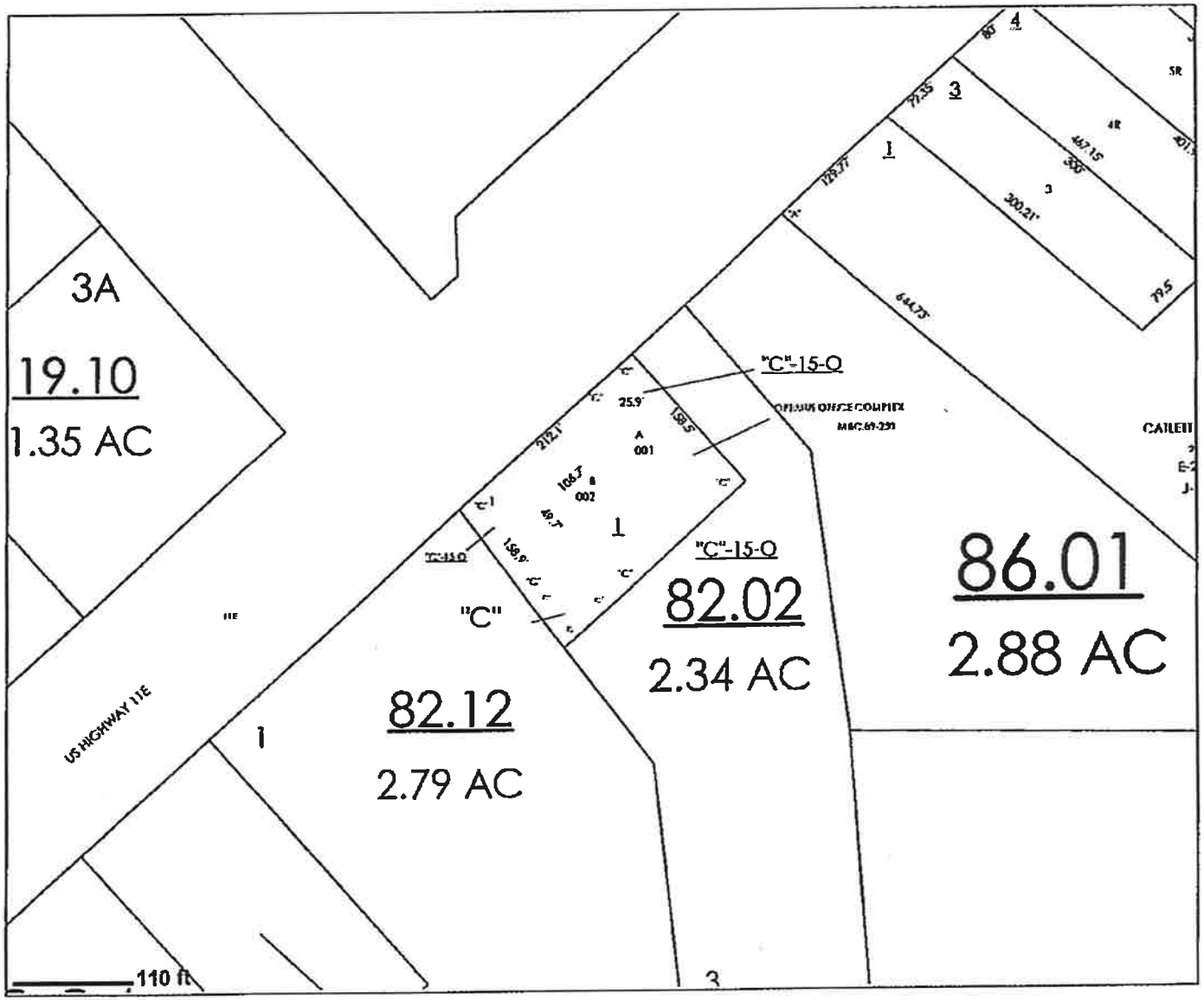
Kim Harvey Looney

KHL:lag

SUPPLEMENTAL #1
January 27, 2017
10:10am

Attachment Section A, Project Details-Item 4-B.1

Plot Plan



TEXT

TEXT_PARCELS

LEADERLINES

PARCELS

JEFFERSON_5 (Image)

JEFFERSON_4 (Image)

JEFFERSON_3 (Image)

JEFFERSON COUNTY, TENNESSEE

DISCLAIMER: THIS MAP IS FOR PROPERTY TAX ASSESSMENT PURPOSES ONLY. IT WAS CONSTRUCTED FROM PROPERTY INFORMATION RECORDED IN THE OFFICE OF THE REGISTER OF DEEDS, AND IS NOT CONCLUSIVE AS TO LOCATION OF PROPERTY OR LEGAL OWNERSHIP.

JAN 27 '17 AM10:09

SUPPLEMENTAL #1

January 27, 2017
10:10am

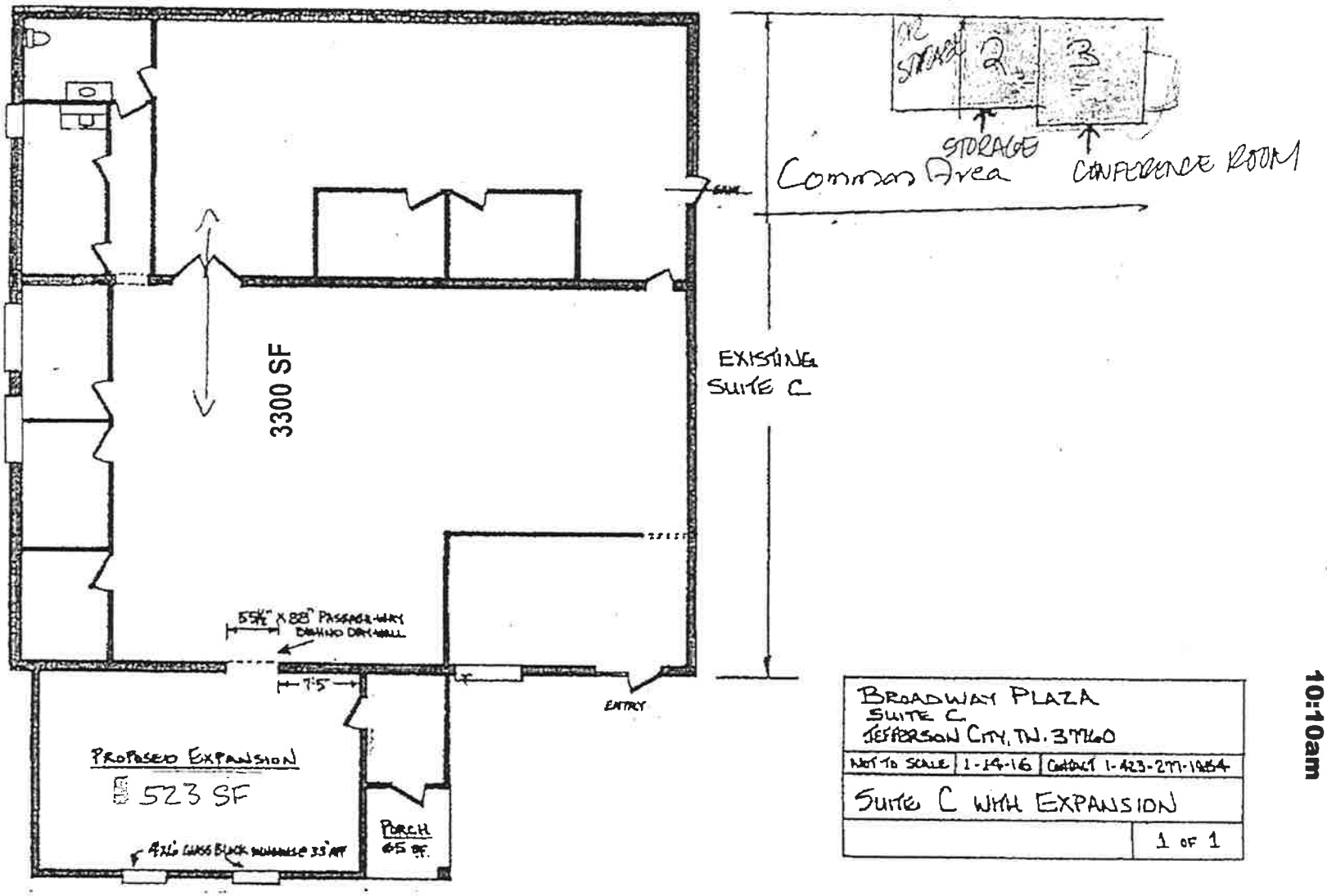
SUPPLEMENTAL #1
January 27, 2017
10:10am

Attachment Section A, Project Details-Item 6 B-2

Floor Plan

4,123 SF

300 SF



BROADWAY PLAZA SUITE C JEFFERSON CITY, TN. 37760		
NOT TO SCALE	1-19-16	CONTACT 1-423-271-1954
SUITE C WITH EXPANSION		
		1 OF 1

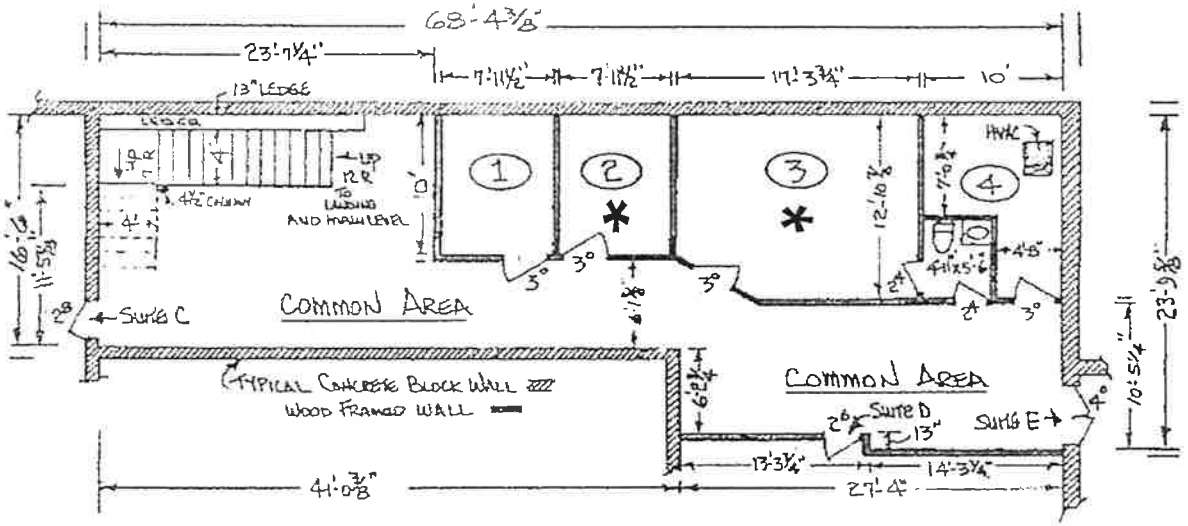
SUPPLEMENTAL #1

January 27, 2017
10:10am

VN

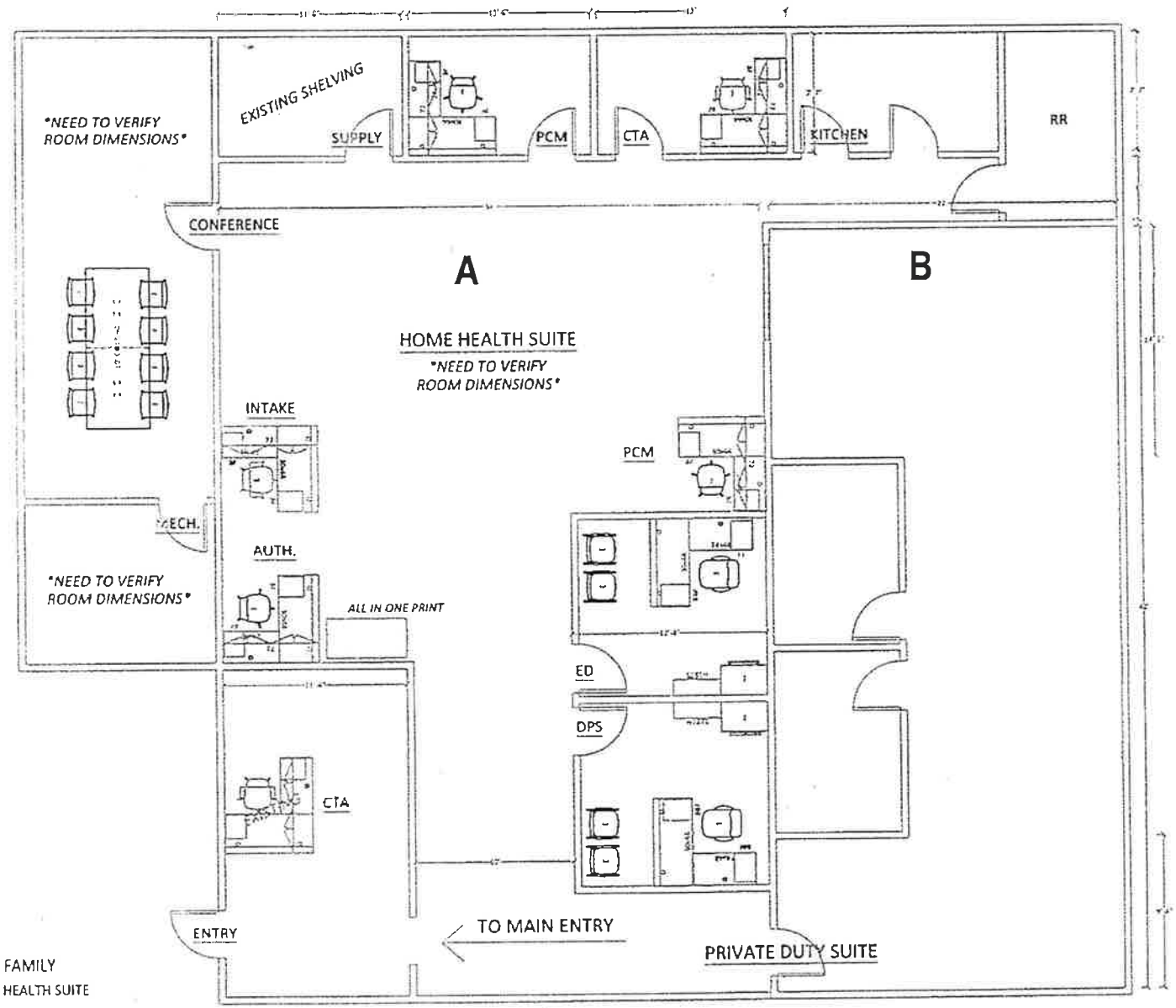
ONLY ROOM 2 AND ROOM 3 OCCUPIED BY APPLICANT

300 SF



J. CITY

FURNITURE LAYOUT FOR AREA A



ALMOST FAMILY
AF HOME HEALTH SUITE

www.OfficeMaxInteriors.com

ALMOST FAMILY
HOME HEALTH

657 BROADWAY
JEFFERSON CITY TN 37760

H.H. JEFFERSON CITY, TN

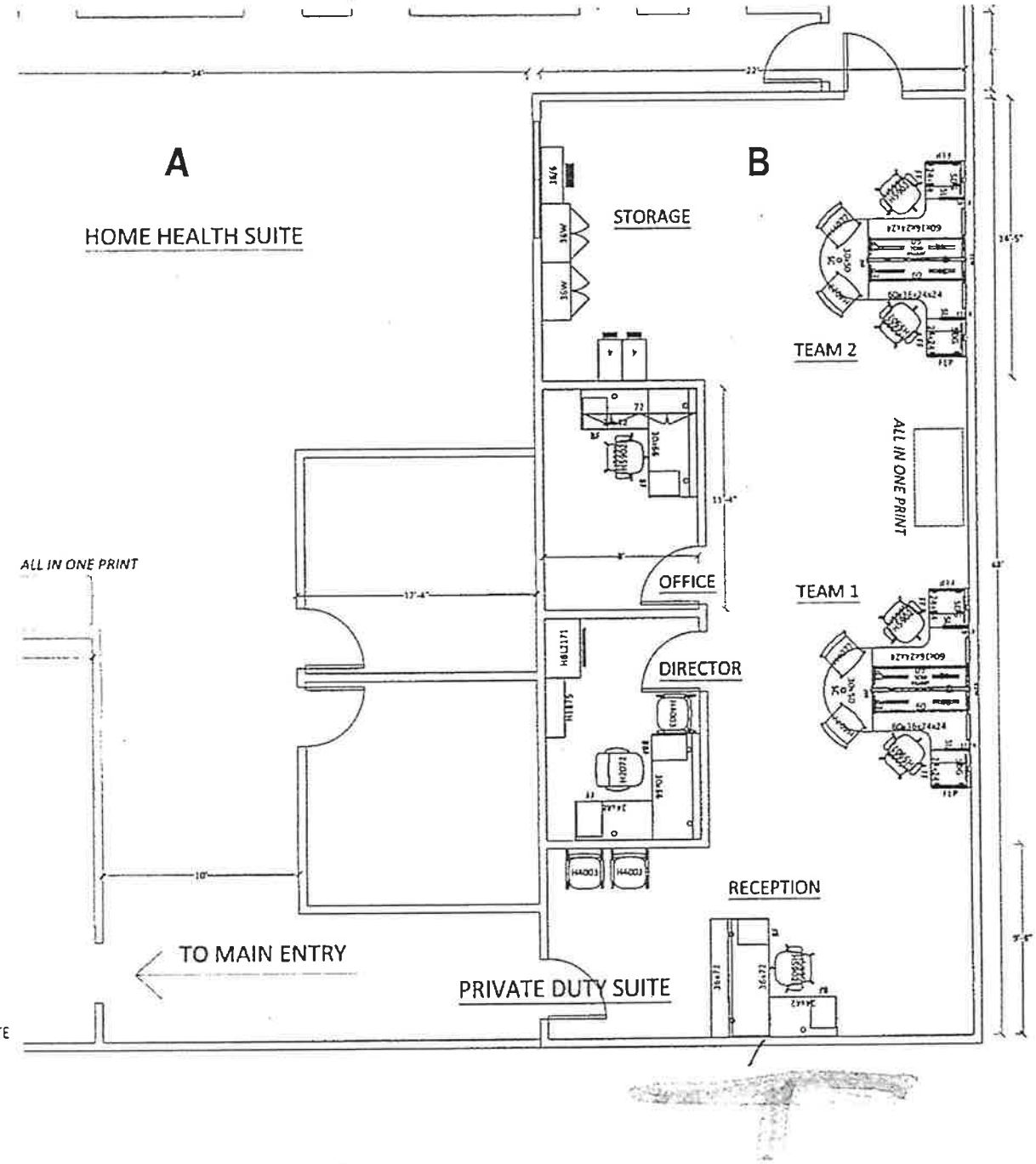
SCALE:
SALES: C JOHNSON
DESIGNER: M HAWKINS
DATE: 01.04.16
REVISION DATES:

SHEET:

January 27 2017
10:10am

SUPPLEMENTAL #1

FURNITURE LAYOUT FOR AREA B



www.OfficeMaxInteriors.com

ALMOST FAMILY
PRIVATE DUTY

657 BROADWAY
JEFFERSON CITY TN 37760

PRIV. DUTY JEFFERSON CITY, TN

SCALE:
SALES:
DESIGNER:
DATE:
REVISION DATES:

SHEET:

SUPPLEMENTAL #1
January 27, 2017
10:10am

SUPPLEMENTAL #1
January 27, 2017
10:10am

Attachment Section B, Need, Item 4.A

Revised Page 20

1. A. 1) Describe the demographics of the population to be served by the proposal.

2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder:
http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/ Geographic Area By County	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Campbell	41,464	41,787	0.1%	N/A	N/A	N/A	N/A	43.0	32,028	9,224	22.2%	13,469	32.5%
Claiborne	33,800	34,713	2.7%	N/A	N/A	N/A	N/A	41.8	34,899	6,944	20.5%	9,407	27.8%
Cocke	36,976	37,663	1.9%	N/A	N/A	N/A	N/A	44.3	31,187	9,178	24.8%	11,710	31.7%
Grainger	23,890	24,577	2.9%	N/A	N/A	N/A	N/A	43.6	35,391	4,706	19.7%	6,106	25.6%
Greene	72,512	74,656	2.9%	N/A	N/A	N/A	N/A	43.7	35,196	14,060	19.4%	15,787	21.8%
Hamblen	65,332	67,028	2.6%	N/A	N/A	N/A	N/A	39.9	37,617	13,504	20.7%	16,276	24.9%
Hancock	6,951	7,007	0.8%	N/A	N/A	N/A	N/A	44.2	26,898	1,815	26.1%	2,396	34.5%
Hawkins	58,771	59,784	1.7%	N/A	N/A	N/A	N/A	43.4	36,927	10,838	18.4%	14,066	23.9%
Jefferson	55,714	58,372	4.7%	N/A	N/A	N/A	N/A	42.3	42,417	8,786	15.8%	12,721	22.8%
Sullivan	158,938	159,749	0.5%	N/A	N/A	N/A	N/A	44.3	40,346	27,439	17.3%	33,818	21.3%
Union	19,903	20,320	2.1%	N/A	N/A	N/A	N/A	41.0	37,351	4,104	20.6%	5,234	26.3%
Service Area Total	564,251	585,656	3.8%	N/A	N/A	N/A	N/A	42.9	35,478	110,598	19.6%	140,990	25.0%
State of TN Total	6,812,005	7,108,031	4.3%	N/A	N/A	N/A	N/A	38.4	45,219	1,600,000	23.5%	1,489,597	21.9%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

SUPPLEMENTAL #1

January 27, 2017
10:10am

Attachment Section B, Economic Feasibility-Item 1

Revised Page 23

Project Costs Chart

SUPPLEMENTAL #1
January 27, 2017
10:10am

PROJECT COST CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 45,000
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Total Construction Costs	
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	
	9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land) Value of Space	$246,432
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify)_____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$291,432
E.	CON Filing Fee		$15,000
F.	Total Estimated Project Cost (D+E)	**TOTAL**	**$306,432**

Response: With the exception of legal costs and the filing fee, there are no costs associated with the relocation of the principal office for the applicant. The applicant already operates the office proposed as the principal office as a branch office.

Property Type: **08 Commercial**

ASSESSOR OF PROPERTY - PROPERTY RECORD CARD

TAX YEAR 2017 JEFFERSON	045	015O	C	001.00		002
	JUR	CONTROL MAP	GROUP	PARCEL	PI	S/I

657 BROADWAY BLVD E
Property Address

Ownership and Mailing Address
KOUSER FAMILY LIMITED PARTNERSHIP #1
P O BOX 1203
TALBOTT TN 37877

Subdivision OPTIMUS OFFICE COMPLEX
BK M 89 PG 250 BLOCK LOT B TRACT
Alt Subdiv
BK PG BLOCK LOT TRACT
Additional Description INCLUDES COMMON GROUND BLDG B; 657 & 673
Dimensions 212.1 X 158.9 IRR 106.7 X 49.7

City 45345 Jefferson City
SSD1
SSD2
Total Land Units 5300
Deed Acres 0
Calculated Acres 0

Map 015O Updated 10/27/2016
Dist 04 Printed 01/13/2017
Card: 1 of 1
Page: 1 of 2

COMMERCIAL BUILDING DATA

Bldg # Identical Units 1
Yr Built 1993 Effective Year 1993 Market Adj Proration
Struct Code 30 Office C&D 1 Date
Grade 1-- Average - Bldg Value 375,850 Factor
Imp Name Class
Other Imps Other Value

RCN	507,918	RCNLD	375,850	Value $/SqFt	59.77
RCN $/SqFt	80.77	%Complete		Area Sum	6,288
%Good	74	Bldg Factor	1	Bus Living Area	6,072
%Good Ovr		Cost Value	375,850		

Info Src 1 Occ 0 Rental Src Year 0 Amount 0 Sched

Foundation	02 Continuous Footing	Floor Finish	11 Carpet Combination
Floor System	04 Wood W/ Sub Floor	Interior Finish	07 Drywall
Party Wall	00 None	Paint/Decor	03 Average
Struct. Frame	00 None	Plumbing Fix	21
Roof Framing	02 Gable/Hip	Bath Tile	00 None
Roof Cov/Deck	03 Composition Shingle	Electrical	03 Average
Cab/Millwork	03 Average	Heating/Air	07 Hvac Split
		Shape	01 Rectangle

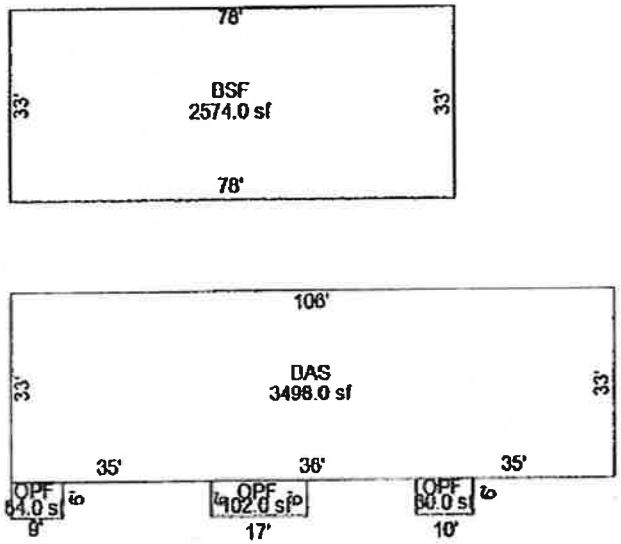
Commercial Interior/Exterior Depr Yr 2014 County Factor 1.00

Line 1 Section 01 From 01 To 01 YrBlt EffYr Area 3,498
Use Type 30 Office WallHt Exterior Wall 11 Common Brick
Structural Frame 0 None Perimeter 278 Class
Finish 100 Partition 3 200% Base, Rm Heat 3 Split Heating (Air 2 Heating And Cooling
Plumbing 3 Above Normal Lighting 2 Normal Condition A Function A
Depr: Physical 21.00 Other Phys Functional External 5 % Good 74.00
VALUES Other Features 4,791 RCN 320,760 SqFt Rate 106.51
% Complete User Adj Cost Value 237,360

Line 2 Section 01 From 01 To 01 YrBlt EffYr Area 2,674
Use Type 30 Office WallHt Exterior Wall 11 Common Brick
Structural Frame 0 None Perimeter -2 Class
Finish 50 Partition 3 200% Base, Rm Heat 3 Split Heating (Air 2 Heating And Cooling
Plumbing 3 Above Normal Lighting 2 Normal Condition A Function A
Depr: Physical 21.00 Other Phys Functional External 5 % Good 74.00
VALUES Other Features RCN 187,150 SqFt Rate 65.54
% Complete User Adj Cost Value 138,490

Commercial Features

Line	Int/Ext	Structure Code	Dim 1	Dim 2	Units	Elev Steps	RCN
1	1	OPF	54	1	1		1,198
2	1	OPF	102	1	1		2,262
3	1	OPF	60	1	1		1,331



APPRAISED VALUES

LAND	28,600
IMPROVEMENTS	427,400
TOTAL APPRAISAL	456,000
GREENBELT APR	
ASSESSMENT	182,400
ASSESSED @	40%
APPROACH	COST VALUE

Value Correlation

	Value
COST	456,000
INCOME	
MARKET	

PARCEL DATA

NBHD C01
Review Flag
Living Units
Water/Sewer 01 Public / Public
Electricity 01 Public
Gas 01 Public - Natural Gas
Topo 0 Level
Road Type 0 Us Highway
Delete Next Year
Greenbelt Review N
Land Apr Date 05/27/2009 By 99
Improvements 1
Mobile Homes 0
NH Trend 1 IMPROVING
Other
Land Use Code 65
Zoning

GREENBELT

Year Recorded
App# Book/Pg

OUTBUILDINGS and YARD ITEMS

Code	Description	Yr Blt	Eff Yr	Area	Grade	Units	Add'l Description	Class	Rate	Cnd	RCN	%Good	Prort	Adj Fact	Value
ASP	Asphalt Paving	1993	1993	24,800	C	1	IRR		1.4202	AV	35,220	10		1	3,520
MSC	Miscellaneous Oby	1993	1993	4	C	1			12000	UN	48,000	100		1	48,000

Total OBY Value 51,520

ENTRANCES

Date	Code	ID
02/18/2011	00 Pcl Review	11

BUILDING PERMITS

Date	Type	Status	Last Visit

MARKET LAND

#	Type	Table	Code	Acc	Front	Depth	Units	Rate	Infl	Fld	Topo	Loc	Size	Mkt	Dep	Adj Rate	Value	Class
1	U	ZZ	10		107	50	5,300	5.40							100	5.40	28,620	
						Totals:	5,300										28,620	

AGRICULTURAL/GREENBELT LAND

#	Mkt Line	Use Type	Soil Type	Access	Acres	Rate	Use Value
				Totals:			

SUPPLEMENTAL #1
January 27, 2017
10:10am

Property Type: 08 Commercial

ASSESSOR OF PROPERTY - PROPERTY RECORD CARD

TAX YEAR 2017 JEFFERSON	045 JUR	015O CONTROL MAP	C GROUP	001.00 PARCEL	PI	002 SA
City 45385 Jefferson City	Map 015O	Updated 10/27/2016
SSD1	Dist 04	Printed 01/13/2017
SSD2	Card: 1 of 1
Total Land Units 5300	Page: 2 of 2
Deed Acres 0	
Calculated Acres 0	

657 BROADWAY BLVD E
Property Address

Ownership and Mailing Address
KOUSER FAMILY LIMITED PARTNERSHIP #1
P O BOX 1203
TALBOTT TN 37877

Subdivision OPTIMUS OFFICE COMPLEX
BK M 69 PG 259 BLOCK LOT B TRACT
Alt Subdiv
BK PG BLOCK LOT TRACT
Additional Description INCLUDES COMMON GROUND BLDG B; 657 & 673
Dimensions 212.1 X 158.9 IRR 196.7 X 49.7

SALES

Date	Book	Page	Price	Adj Price	Vfi	Instr	A/R	Owner
03/03/2015	1255	655				QC		KOUSER FAMILY LIMITED PARTNERSHI
08/14/2014	1236	175	690,000	690,000	I	WD	P	KOUSER AQUEEL & HINA
10/25/2007	904	331			I	QC	E	CROWN HILL ENTERPRISES LLC
02/16/1988	321	37						HAYES H DAVID & SHARON

NOTES

BOB OGLE LAW OFFICE- 669; NAIL PLACE - 675; TN BOARD OF PROBATION & PAROLE --REA L ESTATE REFERRAL SERVICES(677) ; WARNER CHIROPRACTIC 673; LAND IS SF PRICED

SUPPLEMENTAL #1
January 27, 2017
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SUPPLEMENTAL #1

January 27, 2017
10:10am

Attachment Section B, Economic Feasibility-Item 2

Revised CEO Letter

SUPPLEMENTAL #1
January 27, 2017
10:10am

Almost Family, Inc.
9510 Ormsby Station Road, Suite 300
Louisville, KY 40223
502.891.1000 Fax: 502.891.8067

January 13, 2017

Tennessee Department of Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502m Deaderick Street
Nashville, TN 37243

RE: Certificate of Need
Applicant: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
Lic. #: 0000000093

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health has filed a Certificate of Need Application to move its principal office. The Board of Directors of Tennessee Nursing Services of Morristown have approved the filing of the CON Application, and agreed to provide funding for this application. The funding of this project will come from cash reserves of the company.

Tennessee Nursing Services of Morristown is a fourth tier, wholly owned subsidiary of the public company, Almost Family, Inc. As the ultimate parent company, Almost Family, Inc. also agrees to guarantee all financial obligation of the subsidiary for this CON project.

If you have any questions, please feel free to contact me at (502) 891-1044.

Sincerely,

Patrick Todd Lyles
Sr. Vice President & Secretary
Tennessee Nursing Services of Morristown, Inc.

The financial obligations for the Certificate of Need application of Tennessee Nursing Services of Morristown will be guaranteed by the corporate parent.

Almost Family, Inc.

William B. Yarmuth
Chairman & CEO

SUPPLEMENTAL #1

January 27, 2017
10:10am

Attachment Section B, Economic Feasibility-Item 4

Revised Replacement Pages 25 and 26
Historical Data Charts

Revised Replacement Pages 28 and 29
Projected Data Charts

HISTORICAL DATA CHART

☒ Total Facility
☐ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits): Visits	**29,323**	**28,316**	29,806
B.	Revenue from Services to Patients			
1.	Inpatient Services	**$**	**$**	**$**
2.	Outpatient Services			
3.	Emergency Services			
4.	Other Operating Revenue (Specify) Home Health	4,263,273	4,745,213	5,159,118
	Gross Operating Revenue	**$ 4,263,273**	**$ 4,745,213**	**$ 5,159,118**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$ 586,326	$ 586,757	$609,037
2.	Provision for Charity Care	220	262	293
3.	Provisions for Bad Debt	171,087	256,935	136,468
	Total Deductions	$ 757,633	$ 843,954	$ 745,798
NET OPERATING REVENUE		**$ 3,505,640**	**$ 3,901,259**	**$ 4,413,320**
D.	Operating Expenses			
1.	Salaries and Wages			
a.	Direct Patient Care	$ 1,762,152	$ 1,857,064	$ 2,049,979
b.	Non-Patient Care	802,042	857,762	1,021,596
2.	Physician's Salaries and Wages			
3.	Supplies	214,750	201,931	269,860
4.	Rent			
a.	Paid to Affiliates			
b.	Paid to Non-Affiliates	84,782	85,437	91,230
5.	Management Fees:			
a.	Paid to Affiliates			
b.	Paid to Non-Affiliates			
6.	Other Operating Expenses	700,089	619,086	757,509
	Total Operating Expenses	**$ 3,563,815**	**$ 3,621,280**	**$ 4,190,174**
E.	**Earnings Before Interest, Taxes and Depreciation**	**($ 58,175)**	**$ 279,979**	**$ 223,146**
F.	Non-Operating Expenses			
1.	Taxes	$ 5,751	$ 6,347	$ 4,842
2.	Depreciation	7,477	8,732	15,644
3.	Interest			
4.	Other Non-Operating Expenses			
	Total Non-Operating Expenses	**$13,228**	**$15,079**	**$20,486**
NET INCOME (LOSS)		**($71,403)**	**$264,900**	**$202,660**

Chart Continues Onto Next Page

NET INCOME (LOSS)		$_____	$_____	$_____
G.	Other Deductions			
1.	Annual Principal Debt Repayment	$_____	$_____	$_____
2.	Annual Capital Expenditure	_____	_____	_____
	Total Other Deductions	$_____	$_____	$_____
	NET BALANCE	$_____	$_____	$_____
	DEPRECIATION	$_____	$_____	$_____
	FREE CASH FLOW (Net Balance + Depreciation)	$_____	$_____	$_____

x□ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1.	Professional Services Contract	$	$	$
2.	Contract Labor			
3.	Imaging Interpretation Fees			
4.	Administrative/Benefits	$550,750	$450,851	$576,213
5.	Repairs, Maintenance, Utilities, Cleaning	$35,373	$46,446	$57,851
6.	Telecom and Copiers	$109,039	$120,671	$122,498
7.	Other	$4,927	$1,121	$947
	Total Other Expenses	**$ 700,089**	**$ 619,086**	**$ 757,509**

SUPPLEMENTAL #1

January 27, 2017

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PROJECTED DATA CHART

X Total Facility

□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2017	Year 2018
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	30,700	31,621
B.	Revenue from Services to Patients		
	1. Inpatient Services	$	$
	2. Outpatient Services		
	3. Emergency Services		
	4. Other Operating Revenue (Specify) Home Health	$5,313,891	$5,473,308
	Gross Operating Revenue	$5,313,891	$5,473,308
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$627,309	$646,128
	2. Provision for Charity Care	302	311
	3. Provisions for Bad Debt	211,725	217,637
	Total Deductions	$839,336	$864,076
NET OPERATING REVENUE		$4,474,555	$4,609,232
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	$2,101,229	$2,153,760
	b. Non-Patient Care	912,136	934,939
	2. Physician's Salaries and Wages		
	3. Supplies	277,955	286,294
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	70,230	72,337
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	734,909	756,956
	Total Operating Expenses	$4,096,459	$4,204,286
E.	**Earnings Before Interest, Taxes and Depreciation**	$378,096	$404,946
F.	Non-Operating Expenses		
	1. Taxes	$ 4,988	$ 5,137
	2. Depreciation	16,114	16,597
	3. Interest		
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	$21,102	$21,734
NET INCOME (LOSS)		$356,994	$383,212

Chart Continues Onto Next Page

SUPPLEMENTAL #1
January 27, 2017
10:10am

NET INCOME (LOSS)	$	$
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$	$
NET BALANCE	$	$
DEPRECIATION	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$	$

□ Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Professional Services Contract	$ N/A	$ N/A
2. Contract Labor	$ N/A	$ N/A
3. Imaging Interpretation Fees	$ N/A	$ N/A
4. Administrative/Benefits	$566,500	$583,494
5. Repairs, Maintenance, Utilities, Cleaning	$41,834	$43,090
6. Telecom and Copiers	$126,173	$129,959
7. Other	402	413
Total Other Expenses	**$ 734,909**	**$ 756,956**

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January 27, 2017
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Attachment Section B, Economic Feasibility-Item 5.A

Revised Page 30

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$167.58	$173.09	$173.09	$173.09	-0-
Deduction from Revenue *(Total Deductions/Utilization Data)*	$29.80	$25.02	$27.34	$27.34	-0-
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$137.78	$148.07	$145.75	$145.75	-0-

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The applicant does not anticipate any changes to its charges as a result of the implementation of this proposal. The project does not have any incremental revenue and will have no impact on existing patient charges.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Following is information from the 2015 Joint Annual Reports for home health agencies.

HHA	Gross Revenue	Patients	Visits	Rev/Pat	Rev/Visit
Gentiva	$2,040,611	1,912	12,540	$1,067.27	$162.73
Advanced Home Care	$5,562,153	2,287	38,210	$2,432.07	$145.57
Amedisys	$13,632,114	3,099	100,219	$4,398.88	$136.02
Amedisys-Claiborne	$7,701,253	1,551	56,653	$4,965.35	$135.94

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the

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January 27, 2017
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Attachment Section B, Economic Feasibility-Items 6.B and 6.C

Revised Page 31

project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: Not applicable. The applicant is an operating home health agency with an established track record. There are no costs or charges that are related to this proposal. A copy of the 10K for Almost Family, Inc. is included as Attachment C, Economic Feasibility.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	-.02	.07	.05	.08	.09

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: Not applicable.

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January 27, 2017
10:10am

Attachment Section B, Economic Feasibility-Item 7

Revised Page 32

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: The applicant does not anticipate the payor mix changing significantly.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$4,973,270.59	93.59%
TennCare/Medicaid	$124,876	2.35%
Commercial/Other Managed Care	$223,863	4.06%
Self-Pay	0	0
Charity Care	0	0
Other (Specify)_____	0	0
Total	$5,313,891	100%

Note: Because of the home health services it provides and the service area, the amount of self-pay and charity care is negligible compared to the amounts received from payors.

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: The table below shows the current staffing according to the 2015 JAR. The applicant anticipates a reduction in administrative staff as a result of this proposal.

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January 27, 2017
10:10am

Attachment Section B, Economic Feasibility-Items 8.A and 8.B

Revised Page 33

	Position Classification	Existing FTEs 2015	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
A.	**Direct Patient Care Positions**				
	Registered Nurses	4.8	4.8	$55,000	$56,838
	Licensed Practical Nurses	3.0	3.0	$36,500	$36,673
	Certified Nurse Aides	0	0	$20,500	$22,390
	Physical Therapy Services	7.6	7.6	$90,000	$84,767
	Occupational Therapy	2.6	2.6	$85,000	$80,370
	Speech/Language Pathology Services	1.0	1.0	$85,000	$66,645
	Medical Social Services	1.0	1.0	$52,000	$50,743
	Respiratory Therapists	0	0	N/A	N/A
	Home Health Aide	3.2	3.2	$20,500	$19,033
	Homemakers	0	0	N/A	N/A
	Nutritionists/ Dieticians	0	0	N/A	N/A
	Other Health	0	0	N/A	N/A
	Other Non-Health	0	0	N/A	N/A
	Total Direct Patient Care Positions	23.2	23.2	$55,563	N/A
B.	**Non-Patient Care Positions**				
	Administrator	1.0	1.0	$105,000	N/A
	Clinical Director/In-Office Clinical Staff	8.0	7.0	$75,000	N/A
	Office Personnel (Clinical)	4.0	3.0	$60,000	N/A
	Financial/Billing Personnel	0	0	N/A	N/A
	Other Administrative Personnel (Marketing/ Community Education, etc.)	3.0	3.0	$65,000	N/A
	Total Non-Patient Care Positions	16.0	14.0	N/A	N/A
	Total Employees *(A+B)*	39.2	37.2	$76,250	N/A
C.	**Contractual Staff**	28.0	28.0	$25,000	N/A
	Total Staff *(A+B+C)*	67.2	65.2	$52,271	N/A

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

   A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

   Response: There are no less costly, more effective, and/or more efficient alternatives to this proposal. This request to move the principal office from Claiborne to Jefferson County results in one less office for the agency and a reduction in staff so that expenses are reduced as a result of this proposal.

SUPPLEMENTAL #1

January 27, 2017
10:10am

Attachment Section B, Contribution to the Orderly Development Of Health Care

Regional Administrator, Office of Licensure Letter

SUPPLEMENTAL #1
January 27, 2017
10:10am

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
7175 STRAWBERRY PLAINS PIKE, SUITE 103
KNOXVILLE, TENNESSEE 37914-7008

November 16, 2015

Ms. Christy West, Administrator
Suncrest Home Health
409 Cawood Lane
Tazewell, TN 37879

Re: CMS Certification Number #44-7528

Dear Ms. West:

The East Tennessee Regional Office conducted a recertification survey and a complaint investigation at your facility on November 3 - 5, 2015. As a result of the survey, no deficient practice was found.

If you have any questions, please call our office at (865) 594-9396.

Sincerely,

Karen B. Kirby, R.N.
Regional Administrator
East TN Health

KBK:cvb TN00036163

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	447528	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST HOME HEALTH	409 CAWOOD LANE TAZEWELL, TN 37879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS A recertification and complaint investigation (#36163) survey were completed at Suncrest Home Health from 11/3/15 through 11/5/15. No deficiencies were cited under CFR Part 484, Requirements for Home Care Organizations Providing Home Health Services.	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNH177	A. BUILDING: _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST HOME HEALTH	409 CAWOOD LANE TAZEWELL, TN 37879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-26 Initial. A Licensure and complaint investigation (#36163) survey were completed at Suncrest Home Health from 11/3/15 through 11/5/15. No deficiencies were cited under Chapter 1200-08-26 Standards for Home Care Organizations Providing Home Health Services.	H 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SUPPLEMENTAL #1
January 27, 2017
10:10am

Attachment Section B, Contribution to the Orderly Development Of Health Care

Revised Page 41

Project Completion Forecast Chart

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		4/17
2. Architectural and engineering contract signed	N/A	N/A
3. Construction documents approved by the Tennessee Department of Health	N/A	N/A
4. Construction contract signed	N/A	N/A
5. Building permit secured	N/A	N/A
6. Site preparation completed	N/A	N/A
7. Building construction commenced	N/A	N/A
8. Construction 40% complete	N/A	N/A
9. Construction 80% complete	N/A	N/A
10. Construction 100% complete (approved for occupancy	N/A	N/A
11. *Issuance of License	30-45 Days	5/17 - 6/17
12. *Issuance of Service	30-45 days	5/17 - 6/17
13. Final Architectural Certification of Payment	N/A	N/A
14. Final Project Report Form submitted (Form HR0055)	30 days	7/17

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

JAN 27 '17 AM10:10

SUPPLEMENTAL #1
January 27, 2017
10:10am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: TENNESSEE NURSING SERVICES OF MORRISTOWN, INC. CN1612-042

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27th day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires: January 8, 2019.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JANUARY 8, 2019

HF-0043

Revised 7/02

Supplemental- #2
-Original-

Tennessee Nursing Services of Morristown

CN1612-042

waller

SUPPLEMENTAL #2
January 31, 2017
10:18 am

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 31, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc.
CN1612-042
Second Supplemental Request

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 30, 2017, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. Section B. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

The Historical and Projected Data Charts for the proposed project are noted. However, please complete Section G. for the submitted Historical and Projected Data Charts.

Response: Please see revised pages R-26 and R-29 for the Historical and Projected Data Charts included as Attachment Section B, Economic Feasibility, Item 4.

2. Section B. Economic Feasibility Item 6.B and 6.C.

Please provide a response to 6 (C) (Capitalization Ratio). The capitalization ratio is required for all projects.

Response: The long-term debt (in thousands) is $171,153, with net assets of $521,132 (in thousands) for a capitalization ratio of 32.8% for Almost Family, the parent company of the applicant, based on the 10Q for the period ending September 30, 2016.

waller

Please contact me if you have any questions or need additional information.

Sincerely,

Kim Harvey Looney

KHL:lag

Attachments

SUPPLEMENTAL #2
January 31, 2017
10:18 am

Attachment Section B, Need, Item 4

Revised Historical and Projected Data Charts

NET INCOME (LOSS)		$($71,403)	$264,900	$202,660
G.	Other Deductions			
1.	Annual Principal Debt Repayment	$-0-	$-0-	$-0-
2.	Annual Capital Expenditure	$32,131	$12,810	$62,224
	Total Other Deductions	$32,131	$12,810	$62,224
	NET BALANCE	$(103,534)	$252,090	$140,436
	DEPRECIATION	$7,477	$8,732	$15,644
	FREE CASH FLOW (Net Balance + Depreciation)	$(96,057)	$260,822	$156,080

x□ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	Year 2016
1.	Professional Services Contract	$	$	$
2.	Contract Labor			
3.	Imaging Interpretation Fees			
4.	Administrative/Benefits	$550,750	$450,851	$576,213
5.	Repairs, Maintenance, Utilities, Cleaning	$35,373	$46,446	$57,851
6.	Telecom and Copiers	$109,039	$120,671	$122,498
7.	Other	$4,927	$1,121	$947
	Total Other Expenses	$ 700,089	$ 619,086	$ 757,509

NET INCOME (LOSS)	**$356,994**	**$383,212**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ -0-	$ -0-
2. Annual Capital Expenditure	$ 20,000	$ 20,000
Total Other Deductions	**$ 20,000**	**$ 20,000**
NET BALANCE	$ 336,994	$ 363,212
DEPRECIATION	$ 16,114	$ 16,597
FREE CASH FLOW (Net Balance + Depreciation)	**$ 353,108**	**$ 379,809**

□ Total Facility
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Professional Services Contract	$ N/A	$ N/A
2. Contract Labor	$ N/A	$ N/A
3. Imaging Interpretation Fees	$ N/A	$ N/A
4. Administrative/Benefits	$566,500	$583,494
5. Repairs, Maintenance, Utilities, Cleaning	$41,834	$43,090
6. Telecom and Copiers	$126,173	$129,959
7. Other	402	413
Total Other Expenses	**$ 734,909**	**$ 756,956**

SUPPLEMENTAL #2
January 31, 2017
10:18 am

JAN 31 2017 10:18

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: TENNESSEE NURSING SERVICES OF MORRISTOWN, INC. CN1612-042

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31st day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass
NOTARY PUBLIC

My commission expires: January 8, 2019.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JANUARY 8, 2019

HF-0043

Revised 7/02

waller

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P.O. Box 198966
Nashville, TN 37219-8966

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Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 26, 2017

VIA HAND DELIVERY

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
CN1612-042

Dear Melanie:

Please be advised that the applicant requests that the application be placed on the consent calendar. The applicant would expect no opposition to this project since it is not adding any counties to its service area. The applicant does not expect that the proposed relocation of its principal office would affect the criteria of need or quality measures as the applicant intends to continue to operate in the same service area, offering the same high quality level of services following the relocation. The criteria of economic feasibility could be affected by this proposed relocation insofar as the relocation will allow the applicant to reduce overhead by cutting back on administrative and leasing costs. Furthermore, a positive effect may occur with respect to the orderly development of health care in that the proposed relocation will place the principal office of the project in Jefferson County, the county with the highest projected population growth from 2016 to 2020.

If you have any questions or need any additional information, please do not hesitate to call me.

Sincerely,

Kim Harvey Looney

KHL:lag

4817-9866-1182.4